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ABSTRACT

This report discusses the health of adolescents and youth in the tropics. The report is divided into five sections. The first section defines adolescence, youth, the duration of adolescence, the age group and its problems, and societies in adolescence. The second section discusses adolescence in relation to society and culture and focuses on the 7-year cycle and emotional, social, and spiritual maturity. The third section describes health needs of adolescents in terms of psychosocial needs and needs related to physical development. The section also covers adolescent mortality, morbidity, health-related behavior, and perceived health. The fourth section discusses sexuality and health in adolescence. It focuses on sexual behavior, pregnancy and adolescence in Africa, abortion, contraception and planned parenthood, and sexually transmitted diseases. The final section discusses the response to adolescent health needs. The topics of this section include the role of physicians, the role of adults, health at school, primary health care, principles of group work in sex education, participation of youth in the promotion of health, and a model for organizing health services for and with young people. (RJC)

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CHILDREN IN THE TROPICS

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HEALTH FOR ADOLESCENTS AND YOUTH

1989 - N° 180

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The International Children's Centre was created by the French government in 1949, on the initiative of Professor Robert Debré in particular, following negociations between France and the United Nations. Its purpose was to furnish those international and national agencies dealing specifically with child care with training facilities and educational and informational tools in the field of child health and development, viewing children within their family and surroundings.

ICC soon turned essentially toward Third World children and devoted its activities to the training and education of personnel with social, educational and administrative responsabilities as well as medical and paramedical workers. The desire for greater efficiency has led it to work increasingly with trainers and to concentrate its efforts on the methodological and educational aspects of mother and child care programmes.

ICC is also engaged in an attempt to further study — and — action on some aspects of the life and health of children and their family, so as to contribute to practical improvement, particularly in the fields of growth, nutrition, planned parenthood, the control of transmissible and nutritional diseases, preschool and school education, the needs of disabled and underprivileged children, etc.

Over this period of more than 30 years, a large amount of documents on children and adolescents, mostly from the developing countries, has been accumulated. This international documentation has been classified and sorted out, and has been computerized since 1983 : a bibliographic data base (BIRD : « Base d'Informations Robert Debré ») may be consulted anywhere in the world, through international communications networks. ICC also publishes periodicals, educational documents and specialized bibliographic bulletins.

As for its legal status, the International Children's Centre is a foundation under french law of recognized public utility, administered by an executive board with broad international membership.

CHILDREN IN THE TROPICS

REVUE DU CENTRE INTERNATIONAL DE L'ENFANCE

HEALTH FOR ADOLESCENTS AND YOUTH

☐ JEAN-PIERRE DESCHAMPS
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1989 - N° 180

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- Santé publique, santé de la communauté. Villeurbanne, SIMEP. 1980.
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- Les premiers pas dans la vie de l'enfant d'Afrique noire. Naissance et première enfance. Eléments pour une ethnologie de l'éducation. Paris. Editions de l'Ecole. 1972.
- The child and his environment in Black Africa : Essay on traditionnal education. Oxford U. Press. 1983.

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Introduction

Traditionally, health services are not very concerned with adolescents, for a number of reasons :

— children and women of child-bearing age represent absolute priorities, and they constitute over one half of the population in many countries, so that health workers do not have much time to devote to other age groups ;
— adolescents and youth are usually considered to be "healthy" since they do not have the fragility of small children ;
— adolescents and young people attend consultations and doctors' offices infrequently, thus accrediting the idea that they have no health problems ;
— most important, adolescence is a relatively new concept, created in the western world and occasionally viewed as belonging specifically to the industrialized countries.

All of these points are now open to discussion. Sociologically speaking, the phenomenon of adolescence is now universal, although probably less markedly so in those rural communities where traditional ways of life still prevail. It is particularly evident in urban contexts in the developing countries, where the breakdown of traditional family and social models often results in a long, stressful period for children, starting at a very early age, before they are able to complete the difficult process of assuming an adult status.

Often dramatic events are required to stir a new awareness of the situation of adolescents ; the shock then experienced by adults in general and government officials in particular produces the idea that adolescence and youth are "problems" rather than rich, fertile periods of human development. The "problems" may be of many types : student rebellions, juvenile delinquency, prostitution and drug abuse are subjects of great concern everywhere.

Most of young people's "problems" are of a social/psychological nature. It is difficult to dissociate the consequences of psychological development during adolescence, the societal situations in which adolescents participate or to which they are witnesses, and specific health problems. This may explain why health services find it difficult to care for adolescents. They tend conventionally to deal with illness and related action of a medical type, and are ill at ease with health problems with such obvious social aspects, and for which the usual medical or individual solutions are apparently quite ineffective. They are probably also uncomfortable with the peculiar behavioural patterns of adolescents, who seem to avoid them, while simultaneously expecting a great deal from them, and who are difficult to approach, particularly since health professionals have not received any preparation for this type of contact during their training.

This is the heart of the paradox : adolescents seem to be healthy, and in reality they are not ; they do not seem to have any need for health services, whereas their non-attendance of consultations is in fact often due to a misunderstanding.

It is important to take the time to look at the health problems of adolescents and young people, and to ask some relevant questions : what are their health needs, what information and health indicators are appropriate for this time of life ? Their specific demands should be heeded, appropriate action initiated and their preoccupations taken into account when training professionals and organizing working units. Research should be conducted. Over and beyond the problems and the vulnerability of adolescents, the tremendous potential of this period should be taken into account : the positive aspects of adolescence should be viewed, with the capabilities and receptiveness of adolescents, so as to provide them with opportunities to participate in attempts to improve their own well-being, as well as in community development.

SOME TENTATIVE DEFINITIONS

Adolescence

Adolescence may be defined simply as the intermediary period between childhood and adulthood, a transitional period characterized as much by the previous phases and the subsequent ones as by its own specific features. It is a period of contrasts and of paradoxes, as well, as shown by the definition provided by the American sociologist Hollingshead in 1960 : "adolescence is that period in the life of an individual when society no longer views him as a child but does not yet concede him either the roles or the functions inherent in the status of adult."

A more concise definition is required for use in public health, however. A period of life must have a beginning and an end. The beginning of adolescence may be set rather easily at puberty, which is the point in the development process that marks the end of childhood. It is much more difficult to determine an end point, however. Adulthood begins when an individual has acquired a status that is defined, for the most part, by economic, social and familial independence.

Adolescence can only be defined with reference to sociological facts, regardless of whether the question is approached by considering the social status of adolescents, as HOLLINGTON does in his definition, or by considering access to the status of adult as its end point.

By contrast, the beginning of adolescence is a biological, somatic occurrence : it is the time when the human being acquires the ability to reproduce. This does not occur all at once, of course. Puberty is an ongoing process covering several years of an individual's life, although it is a common notion that young people are usually pubescent at age 13, for girls, and 14 or 15 for boys.

In fact, the transformations connected with puberty actually begin much earlier, generally between the ages of 9 and 12-13, somewhat later in some children. It would be questionable, then, to set an "age" for puberty, unless some specific, easily measurable indicator is available. Such an indicator does exist for girls : it is the age at which menstruation begins, or menarche. As a rule, menarche occurs earlier in urban settings than in rural areas, and in privileged social classes than in the less advantaged classes.

At the population level, the average age at menarche is in fact a good indicator of health, provided the level of social and economic development of the population and the health and nutritional status of girls during the first years of life are taken into consideration.

Within a given population group, the age of occurrence of menarche varies considerably. It is affected by the socioeconomic level of families, but also by familial genetic factors, which condition the fact that normally developed girls may first menstruate at the age of 9 or 10, for the most precocious, or as late as age 15 or 16.

Another chronological indicator, one which is valid for both sexes, may be used, but it requires a longitudinal investigation of height growth. This is the "growth spurt" (see below), the point of maximal increase in height, after which the rate of growth slows down ; statural development gradually comes to a halt several years later. In Western Europe and North America, at the present time, the growth spurt occurs between ages 12 and 12.5 years in girls and at age 14 in boys, on the average. In Asia and Africa, it occurs between 12.5 and 13 years in girls, and between 14 and 15 in boys.

Youth

There is no need to emphasize the relativity of the concept of youth. Independence is rarely acquired overnight : it is exceptional for legal responsibility, economic autonomy, social autonomy and familial independence to be achieved all at once. The age of 20 is often arbitrarily defined as the end of adolescence, but some people unhesitatingly set the limit at age 25, on the basis of the great similitude of the problems (in the health needs of males, in particular) faced by the 15-20 and 20-25 year-old groups. In this view, we are justified in linking the notion of "youth" with the notion of adolescence, and in speaking of adolescents and youth.

Duration of adolescence

Adolescence may be only a very short period. The anthropologist Margaret Mead has shown that there is no such thing as a period of adolescence in the primitive societies she studied. The passage from childhood to adulthood, which occurs practically at puberty, is achieved almost instantaneously through initiation rites. These clearly indicate the cultural importance of this passage and of the recognition by the group of the new role acquired by the individual when he or she reaches a certain phase of development. In these communities a person is either a child or an adult : there is no intermediary status.

In modern societies, be they industrialized or developing, the beginning and the end points of adolescence are no longer one

and the same, as in primitive societies. They are separated by a long, and gradually lengthening, period of time.

The average age at puberty is constantly declining. The following diagram (figure 1) shows how age at menarche, which exceeded 16.5-17 years in Scandinavia a century ago, has gradually dropped to the above-mentioned ages. The same phenomenon probably occurred in a similar manner in other European countries, since age at puberty does not depend either on the latitude or on the climate, contrary to earlier beliefs, but solely on a population's health and living conditions. Indeed, when the standard of living improves in a country or a population group, puberty occurs at an earlier age. It is probable that the age of puberty in both sexes dropped by four months per decade in European countries between 1900 and 1970, representing approximately a one-year drop per generation. There is little evidence in support of the idea that this increasing precociousness is linked with the "sexual stimulation" experienced by young people today, as some people contend. The phenomenon is in fact a more global one, well known as the evolutionary acceleration of growth, and which also implies a gradual evolution of weight, height and perhaps of social and economic development. This process seems in fact to be nearing its conclusion in the most advantaged industrialized countries, and the average age of puberty in girls will not drop far below 12 years, for instance. Age at puberty is also declining gradually in the developing countries.

Concomitantly, the end of adolescence, however difficult it may be to define it precisely, is increasingly delayed. As compulsory schooling is extended and the duration of academic and occupational training increases, while the specific problems linked with employment make social integration increasingly difficult, young people unquestionably tend to postpone the moment when they become adults.

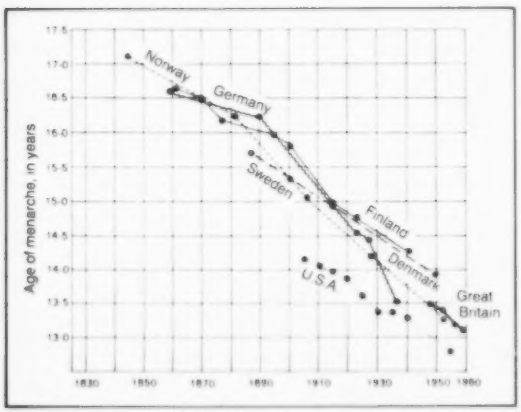

Figure 1 - Secular drop in average age of menarche in several countries

Source : TANNER. In : MONNIER J. et al. Santé Publique. Santé de la Communauté. Villeurbanne, SIMEP, 1980, 443 p.

"Children mature at an earlier age, while at the same time they spend more years in school, which is one of the main causes of their delayed economic and social emancipation ...", as R. Debré so aptly said.

As we have seen, adolescence now begins sooner and ends later. It covers a number of years. From 12 to 18 ? From 13 to 19 (in other words, the teenage years) ? From 10 to 20, or even later ? If we are to reason in terms of age, ages 10 and 20 seem to be satisfactory boundaries, particularly since they coincide with the age groups conventionally used for demographic and health statistics : 10-14 years

and 15-19 years. The extension of the end point to age 22 or 25, including the category called "youth", results in the paradox pointed to by O. JEANNERET as early as 1968 : "Childhood now lasts only about ten years, whereas adolescence now extends over a period of about fifteen years."

New age group, new problems

The same social phenomenon - economic development and improved living conditions - underlies both the lowered age of puberty and the prolongation of the learning period, resulting in the lengthening of adolescence. Perhaps the greatest paradox of adolescence is the gap between potential and power, between the capabilities of a body and a mind endowed with new abilities, and the constraints of a social system in which adolescents have no well-defined functions. Further, the passage is now so wide that adulthood seems to be very remote, and its image blurred, when viewed from the bank of childhood. Adolescence can no longer be considered a passage ; it is a specific period, with needs and a culture of its own.

In the space of a few decades, a new group has come into being, representing 16 % of the population in Europe (10 to 19 year-olds) and 20 to 25 % in the developing countries.

The first novelty resides in these numbers.

In 1985 the world counted one billion adolescents aged 10 to 19 years, and 1.5 billion 10 to 24 year-olds : almost one fourth of the world population. Four fifths of these live in developing countries. Between 1985 and the year 2000, the number of adolescents throughout the world will increase by 9 % ; in fact, a 27 % increase will occur in Latin America and the Carribean area, with figures as high as 51 % in North Africa and the Middle East and 66 % in sub-Saharan Africa.

Aside from that, are the problems of adolescence really new ? Are they actually the fruit of recent changes or are they only the modern version of ancient problems, of the eternal problems of youth, prevailing throughout our history, from Plato through Rousseau, to the present day ?

"Today's adolescents seem quite different from traditional adolescents : they have become a problem", writes I. Léger. Adolescence, "which has suddenly become an age group in twentieth century civilization", has become the object of considerable research since the 1960's. "Should this new interest be attributed to the evolution of our society, so fascinated with novelty, which has now turned its attention to adolescence following a period of polarization on childhood ? Or is a rather spectacular transformation of adolescence itself actually occurring, one which seriously questions the adult world ?" asks I. Léger. "Recent events are more suggestive of the latter hypothesis", she adds.

In the opinion of L. Debarge, adolescence is partly an "eternal problem" and partly a "modern problem" :

"The abundant literature devoted to this question may be put under two headings : "adolescence, an eternal problem", which heading

would contain all of the conventional approaches to the question, including a great many of the most recent, serious medical and social-psychological investigations designed to shed light on some new dimensions of adolescence, and more specially on the problem of teen-age gangs, the extent and description of juvenile delinquency and the development of an "adolescent market" on the economic level, the success of magazines for adolescents, the influence of the adolescent public on radio and television, the propagation and exploitation of the myth of adolescence, etc.

The same old problem. The first of these two headings would be justified by the existence of a permanent, universal and one might say classical problem of adolescence, which is, so to speak, the problem of the biological and psychological mutation of all human beings, the awakening of sexuality, growth and the identity crisis, tension with sources of authority, be they familial or academic, civil or religious, the conflict of generations, the incomprehension and the opposition between the impetuous enthusiasms and tremendous illusions of youth and a world of adults made cautious by their reflexions and pragmatic by their experience of life.

The modern aspect of the problem. The second heading seems to be justified by the new dimensions recently donned by adolescence. Indeed, youthfulness now generates perplexing, apparently previously unheard-of occurrences within present-day society. These are related to the deepseated transformations that affect society, in conjunction with the population explosion, urban development, the extension of mass communication, industrial mutations, changes in standard of living and more generally, with the upheavals in and the occasional disintegration of existing social systems.

There is a risk of overlooking the modern problem of adolescence - that is, the unprecedented problem facing present-day societies and their members, that of adolescence constituted as a consciously existing social group, exalted by a myth and faced with a terribly disoriented adult society in the midst of a tremendous mutation. This is a "modern" problem in two respects : in its form and in its content. In its form : that is, by the angle at which situations are approached ; in its content : that is, by the type of facts that draw attention... Psychologically speaking, the modern problem of adolescence is not only one of the adolescence of individual people, but more deeply, it is the problem of the adolescence of societies themselves".

Societies in adolescence

Debarge coined this expression in the 1960's. It is a particularly apt description of the social, economic, and cultural mutation experienced by most developing countries. No longer reduced to a state of "infantilization", as they were during the colonial period, they are in search of their own identity, and sometimes hesitate between contradictory models of development, experiencing great difficulty - and sometimes an impossibility, for the time being - in achieving complete autonomy.

These upheavals, hesitations and contradictions deeply affect generations of adolescents and youth, who are also in search of

their identity and their autonomy, and are thus faced with a double process of adolescence - their own, individual and "micro-social" one (at the scale of their social group, and of the community in which they live) and a "macro-social" one, affecting their society as a whole.

The two processes are closely intertwined. Young people in developing countries are undoubtedly the group that is most crucially faced with difficult choices or haphazard compromises between their own basic cultural values and the western values vehicled by a social and cultural model made excessively attractive by its apparent facility, opportunities and affluence. The mass medias, and the press and television in particular, propagate endless images of western or westernized societies based on the power of money, but even more, on a materialistic and individualistic philosophy.

There is no doubt that the clash between cultural models is most obvious and most violent in the large metropolises of developing countries. There is a close link between the intense urban development experienced by third world countries and the appearance of adolescence and youth as a social group in developing countries. As H.L. Friedman, of WHO, points out, "urban development often involves a transition from traditional rural society, in which young people are part of an extended family, implying a number of different adult roles for young women, for which parental models are available, to social contexts in which rapidly advancing urban development and industrialization often push them to migrate alone to cities or their outlying areas. There, it is increasingly difficult to obtain the needed professional qualification, and they are assailed by new and often completely foreign ideas vehicled by the medias, tourists and migrant workers from other countries, while moneyed interests encourage their aspiration to a situation that is rarely within reach in the existing social context."

Traditional values have collapsed, but have not been replaced by other, coherent values ; the uncertainties connected with economic development make it difficult to conceive a project for one's life : these are truly "aggressions" for young people, to which they respond in a variety of ways, judged more or less appropriate by the society in which they live - to the point that some fear them and, in turn, consider them as an aggression against which protection is required. This situation takes a toll on young people's life, health, happiness and freedom, leading them into risky action or into dependency resulting in fanaticism or drug abuse ; they have no future beyond the present moment, since they are deprived of any clear vision of a real, possible future.

Adolescence and youth are truly social and cultural phenomena, at present. The anthropological viewpoint is therefore essential to any understanding of them : this viewpoint is expressed in the following chapter by P. Erny ; it completes that of health professionals, while providing further detail.

ADOLESCENCE IN RELATION TO SOCIETY AND CULTURE

■ PIERRE ERNY

It is difficult, and perhaps vain, to attempt a univocal definition of adolescence. The approach differs according to whether biological or cultural criteria are given preference, and the attendant conclusions are necessarily different. Adolescence is linked to a maturation process experienced by all living beings. There are several types of maturation, however, and consequently, several types of maturity.

The seven-year cycle

A study of the temporal organization governing the first third of human life in most European countries only a few years or a few decades ago shows the striking emphasis placed on seven-year periods of evolution. As is still the case in some eastern European countries, elementary school education began at age seven, believed to be the "age of reason". It ended at age fourteen, at which time a religious rite such as the first communion or confirmation was usually celebrated. Twenty-one was the age of conscription for men, and of civil and legal responsibility.

These social landmarks obviously coincided with biological events : permanent teeth are acquired toward the age of seven, age fourteen is the approximate time of puberty and sexual maturity, and twenty one is the age at which skeletal growth usually ends.

These biological events clearly correspond to psychological mutations as well. The period extending from birth to age seven is characterized by an extraordinary vitality in growth, development, the assimilation of language and of the observed customary behaviour ; imitation and the assimilation of models are the prevailing modes of behaviour. Little is remembered of this period, in general. By contrast, the period extending from age seven to age fourteen is characterized by the sharpening of memory : children are anxious to learn, but also to increase their proximity to the prestigious individuals whose authority they acknowledge. This is therefore the best period for schooling. With puberty and during the entire period usually known as adolescence comes the desire to acquire personal experience, to apply one's own judgement and will in an independent manner.

It is perhaps no accident that seven-year periods are so important in the religious rites, the legends and the folk tales of different peoples. Biology also tells us that in a lapse of approximately seven years, the substance of a person's body changes almost completely : he or she is no longer physically the same. Seen from this angle, the problem of adolescence may seem quite simple : the most fundamental plane of physical growth, which serves as a groundstone for all others, would involve a natural periodicity, with its discontinuities and its crises, so that an adolescent might be

defined as the young individual engaged in the third seven-year period of life.

Things are not that simple, however. First, biological facts fluctuate considerably : age at puberty ranges from eleven to eighteen, depending on the ethnic group, habitat, culture and lifestyle, and this completely modifies the problem. Further, other types of maturity, be they psychological, emotional, social or spiritual, are perhaps not as closely connected with biological factors as one would be tempted to believe at first glance.

Emotional maturity

The sexual maturity acquired at puberty definitely creates some internal upheaval within the body, but its finality is turned outward, it is "other-oriented" maturity. It guides the individual toward the forming of a couple, and the extension of that couple into a family. If the ties established are to be at all harmonious and stable, enough to actually achieve their finality, both partners must have reached a degree of emotional and psychological maturity. Ego-centric men-children and women-children, intent only upon the satisfaction of their personal desires and insensitive to anything but their own playful hedonism or their search for prestige are not mature enough to accept the long and even very long-term responsibilities involved in the establishment of a secure, trustful climate within a couple, and even more so, in the harmonious socialization of children. This type of maturity depends upon the education received by the individual, and by the environment in which he or she was raised ; however, these influences and this atmosphere are in turn conditioned by a number of sociocultural factors.

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Let us take an example. According to the more or less stereotyped judgements passed by one society on another one, it is quite common for the inhabitants of one country or another, taken as a whole, to be considered emotionally immature, although possibly possessing great sexual vitality. One reason for this may be that mothers tend to be overly possessive with respect to their sons, while giving them the impression that everything is due to them, that the world revolves around them and that they are entitled to demand complete submission, particularly from women. An attitude of this type may be functional in a family system based on the pre-eminence and even the dictatorship of men, and in which the emotional aspect of the marital relationship is considered at best as an unimportant epiphenomenon. On the other hand, it will be considered perfectly immature in a context in which sexual ties are based on reciprocity of feelings and of expectations.

If physical maturity itself, then, depends on a great many environmental and cultural factors (diet, living conditions, intensity of neurosensory stimulation, more or less intense erotization of relationships, etc), then it is far more evident that what may be called emotional maturity is meaningless when deprived of its reference to a given sociocultural context. In a civilization based on the values of personal autonomy, such as they prevail in modern-

day western Europe, emotional maturity involves positive tolerance of frustration and solitude, along with a capacity for distantiation, self-determination and oblativity. The individual must be able to view and to respect his or her partner in and for him or herself, and not only for any expected advantages (such as pleasure, work, children, prestige, social relations, wealth, alliances, etc). The fact that normative terms are most appropriate here ("the individual must") clearly indicates that within a given environment individuals inevitably situate themselves with respect to a value system correlative to a type of social organization, which system is expressed in terms of morality, of a way of conducting one's life that is considered normal, or at least acceptable. This is only possible, however, if children receive an education consistent with these views. Autonomy, considered the supreme value in our civilization, is the exact opposite of the values cherished by all cultures based on organic solidarity and on the interdependence between members of a same clan or family group. In such cultures the issue is not learning to be autonomous, but learning to be independent in accordance with a specific model.

There is always much to learn by rereading Margaret Mead's study of the Samoan Islands in the 1920's. It is one of the very first investigations of adolescence outside of Europe, and perhaps provides one of the most striking illustrations of the need for a sense of relativity in any approach to psychological phenomena with respect to culture, and in any attempt at an in-depth understanding of the mentality of adolescents in a given place and at a given time (1).

Social maturity

Individuals may be considered socially mature when they fulfill the conditions set by their own community in order to be considered a full-fledged member, with all of the attendant rights and duties.

Sociocultural criteria are of course all-important here. In the past, the difference between adolescents and adults was clearcut. Adolescents were individuals who had not yet achieved adult status, who were in a preparatory phase still characterized by a degree of dependency, a somewhat inferior status with respect to knowledge and know-how, as well as a degree of irresponsibility. Two main criterias were traditionally utilized to define the stable, definitive state of adulthood : the ability to earn a livelihood by practicing a socially recognized vocational activity and the shouldering of family responsibilities, through marriage. In less technologically advanced societies, this social maturity would follow closely on the heels of physical maturity, inasmuch as children shared the life of adults completely, and therefore had nothing more to learn at a very early age ; inasmuch, too, as parents were anxious to marry children very young, since they lived in the security of the family cocoon, and would continue to do so throughout their life. In many social contexts, too, social maturity in no way means autonomy, since the son remains under the father's authority as long as the latter is alive.

(1) *M. MEAD.* Coming of age in Samoa. 1928.

These criteria have lost much of their relevance at present. Not only is "preparation for life" extended in time, to a point - where students are concerned - that would have been considered absurd in the past, but again, the social situation (vocational mobility, unemployment, etc) and the rapid evolution of technology often require several periods of retraining or refresher training in the course of a career. Adults are therefore no longer the replete, stable individuals they seemed to be years ago. In a sense, it may in fact be said that an unfinished state has become the norm and the rule. The same evolution has taken place in the field of sexual and family life. Now that contraception has been popularized, pleasure and reproduction may be effectively dissociated. It is possible to consider founding a couple in which the arrival of children, with the attendant responsibilities, is temporarily excluded. Gradual apprenticeship may then replace the sudden passage that was formerly the general rule. Instead of achieving a sex life once and for all, it is now possible for people to view sexuality as a domain of never-ending exploration, the phases of which extend over an entire lifetime. These cultural traits increasingly blur the distinction between adolescents and adults, however. Young people are now viewed as surprisingly mature, whereas it would be more appropriate to speak of a sort of juvenilization of existence as a whole.

Spiritual maturity

Spiritual maturity will only be mentioned in passing, here. It is a question of inner unification, and tends to be attained during the second half of life rather than during the first half. Since it is up to each individual to accomplish a living synthesis of all of his or her components and experiences, to actualize his or her virtualities and to fully express his or her innermost being, in a more or less conscious manner, adolescence necessarily constitutes a decisive phase of self-discovery, exploration, orientation, choice and imagination : many of the people whose lives were most successful may perhaps be said to be those who fulfilled an adolescent dream. Cannot the ultimate goal of every individual existence be said to be the birth of an original Self, on which all societies are necessarily built ?

Similarities and differences

Maturity, then, is of four types. These may be divided into two categories :

— those that are experienced as being external to the individual : physical maturity and social maturity ;
— those that are linked with internal evolution : emotional maturity and spiritual maturity.

In any case, these are staggered in time, but to a differing extent depending on the social context. Two extreme cases may be defined :

— those societies in which sexual maturity and social maturity are in close proximity, and may even coincide. As soon as puberty is reached the individual is married and integrated in economic life ; as a result, adolescence is minimized, or even nonexistent ;

— those societies in which a considerable lapse of time separates the two types of maturity, and in which an intermediate period develops and becomes institutionalized ; a period of indetermination, often involving doubts and maladjustment, and sometimes resulting in quite specific behaviour patterns.

Innumerable ethnological examples of the former process may be cited. The latter is relatively rare, but is not exclusively correlated with modern societies. Here too, two cases may be differentiated : one in which the gap between the two types of maturity is overcome by the existence of a free, playful sex life, and one in which sexual continence prevails. The chances are that reactions will be quite different in the two cases. Last, in reference to an idea expressed by the author elsewhere (1), there are in fact two main types of society : those in which "adult" models prevail, including during childhood and youth, and those in which infantile and juvenile models leave their imprint on adult life (1).

Two approaches to adolescence

These brief remarks show that two different perspectives may guide approaches to the questions raised by adolescence, including its very definition :

— one views it as a period of life whose limits are somewhat fluctuating but possessing a number of universal physical and psychological characteristics : it is a "natural" phase in the evolution of human beings, and therefore an unavoidable one ;

— the other views it as a contingent occurrence, completely dependent upon social circumstances : everything depends on the time at which the most important forms of maturation occur - that is, physical and social maturity, which condition the other two to a large extent. When they are practically contemporary, the phenomenon of adolescence may be claimed to be nonexistent. As the gap increases, the phenomenon grows clearer, and becomes explosive in our modern societies, in which the period of waiting, preparation, temporary integration, indecision and anxiety often lasts ten to fifteen years. Adolescence then becomes a primary social fact, which creates its own universe, with its fashions, its means of expression, its market, its leaders and its stars, its organization, etc. The question occasionally arises as to whether the horizontal stratification in terms of age groups has not become more relevant than the vertical stratification in terms of social classes.

In the opinion of this author, there is little doubt of the existence of a periodicity in the bio-psychology of human beings, and scientific criteria may well confirm the relevancy of the seven-year cycle, considered so important by a great many traditions. These are only the building's foundations, however, and many different edifices may be constructed on the same foundations, depending on the site, local tastes and customs. Cultures and their offshoots are like flowers, whose variety and luxuriance conceal their roots.

(1) ERNY P. Ethnologie de l'éducation. Paris, PUF, 1981. The author refers to specific examples, and more specially to the Samoan Islands (p. 85) and to the Murias of India (p. 66).

HEALTH NEEDS OF ADOLESCENTS

Health needs may be approached in several complementary ways : one approach is based on the study of basic requirements, both biological (food, sleep, physical exercise) and psychological, another studies health-related behaviour ; there is also an epidemiological approach and a "developmental" approach, since adolescence is a period of intense development. Alongside of the needs identified by professionals, much attention must be paid to those needs mentioned by young people themselves, and to their demands with respect to health.

Psychosocial needs

A. Maslow's definition of "basic needs" applies very well to adolescents :

- Physiological needs : oxygen, food, sleep, etc.
- Security-related needs : stability, freedom, freedom from fear, protection, "order", etc.
- Needs related to belonging and love.
- Needs related to esteem and prestige : desire for a stable self-assessment based on solid grounds and usually corresponding to a high status.
- Needs related to self-accomplishment : need to be creative. Maslow emphasizes the existence of considerable inter-individual differences. This need frequently remains unsatisfied, both in the work context (routine, insecurity, conflicts...) and in leisure-time activities (stereotyping, passiveness, boredom).
- Needs related to knowledge and understanding : curiosity, exploration of new horizons and new sensations.
- Aesthetic needs.

Maslow's definition is instructive, and quite appropriate for adolescents ; it also indicates their vulnerability. Their need for security contrasts with their frequent anxiety concerning their social and vocational prospects, as well as the ecological future of the planet and the risks of international conflicts. The satisfaction of the need to belong and to be loved is at the root of much adolescent behaviour : they seek friendship and affection, create couples, belong to gangs or sects. The same is true of the need for esteem and prestige, or the need for self-accomplishment, the satisfaction of which is not facilitated by the prolongation of schooling, frequent academic failure, high unemployment rates and the difficulty in expressing creativity... Adolescents find many responses to the need for knowledge, understanding and discovery : their itineraries provide numerous opportunities to make discoveries, be they physical (sporting performances, sexuality), psychological or social (friendship, love, social relations, aggressiveness, disobedience to certain family and social rules and norms, etc). This may be illustrated by some more immediately relevant aspects of the will to discover : sexual experiences, travel, running away, "risk-taking" behaviour, consumption of drugs and alcohol, delinquency, etc.

This approach to the psychosocial needs of adolescents and youth should be stressed. Indeed, it considers their health "problems" - use of drugs, smoking or drinking, early undesired pregnancies, sexually transmitted diseases, accidents, suicides, etc - in an overall perspective, the perspective of adolescence, and not as a series of unrelated occurrences.

Although each of these problems may be viewed separately for educational purposes, it is important that they all be linked to their common denominator : the non-satisfaction, or the search for satisfaction of the specific psychosocial needs of adolescents and youth within a difficult social context.

It is just as important that a specific solution not be sought for each of these "problems" - and more will be said of this below. The solutions to the health needs of adolescents and youth require an overall approach to adolescence, rather than the opening of one or another specific box ("drugs", "accidents", etc), depending on the circumstances, the current emergency or the fears of adults.

Physical development

The essential development is puberty, which marks the beginning of adolescence. It is actually a many-facetted occurrence, including :

— changes in height growth and in body proportions ;
— the development of the gonads, the reproductive organs and the secondary sex characters, with the ability to procreate ;
— changes in the body composition, and more specifically in the amount and distribution of body fat.

These different events take place at the beginning of adolescence. The individual, inter-group, and inter-sex variations in their occurrence and their progression, and even more, their possible dysharmony and occasional dysfunctioning make them the dominant factor in the early adolescent health picture.

These phenomena, as a whole, are governed by the endocrine glands, whose activation - the starting point of puberty - remains relatively mysterious. The "starting signal" is probably given by the brain and transmitted to the hypothalamus - perhaps in the form of an alteration of the hypothalamic receptors' sensitivity to the sex hormones - producing the secretion of gonadotrophin-releasing factors which in turn authorize the pituitary secretion of FSH and LH. It is also probable that the gonadotropic hormones themselves affect the functioning of the brain as well as physical growth, but little information is available as yet on this chapter of human psychobiology, and only physical development will be discussed here, with some remarks on the psychological and educational implications of somatic modifications.

Growth and height

The rate of height growth, which is very high during the first year of life, declines rapidly thereafter, levelling off between ages 6 and 10 years (with an annual increment of 5 to 6 cm), then rises suddenly again at the beginning of puberty. The annual height increment then peaks, with an average of 9 to 10 cm for boys and 8 to 9 cm

for girls. The rate of growth curve (figure 2) shows a peak at an average age of about 12 in girls and 14 in boys.

After this spurt, the rate declines rapidly, then levels off. Most of growth during the spurt involves the trunk. The limbs remain relatively unchanged after puberty, and residual growth is the result of lengthening of the trunk only.

Primary and secondary sex characters

The increase in testicular volume may be assessed using a variety of orchidometres. It is more usual to study certain secondary sex characters : size of the penis and pubic hair in boys, growth of breasts and pubic hair in girls. Tanner has described stages of pubertal development, on the basis of these four indicators. Their assessment is a usual procedure in paediatric endocrinology and public health. Modifications in facial and axillary hair as well as in the voice are well known, as are changes in the transverse body proportions : width of shoulders and of the hips, in particular.

Amount and distribution of body fat

The rate of increase in subcutaneous fatty tissue thickness declines in the years preceding puberty. In boys, this rate becomes negative at puberty : in other words, boys generally become "thinner" at puberty, while their muscles and bones grow rapidly. In girls, the layer of fat continues to increase during puberty, although at a slower pace than in previous years ; this pace quickens again after puberty. These changes affect the trunk more than the limbs.

Adolescents and their body

The physical changes connected with puberty are major ones, and oblige adolescents to adjust to a new body image, while the considerable inter-individual differences in the calendar of pubertal changes produce strong fear of "not being like other people".

Height growth changes the body's proportions, and this itself is not always easy to accept : movements seem awkward, clumsy, and people readily mock the traditional clumsiness of these oversized children, so physically unassured, and who seem to be strangers in their own body. This also results in extraordinary differences in

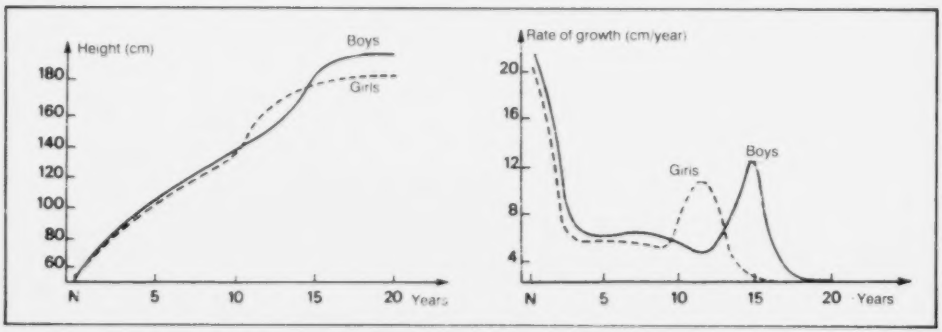


Figure 2 - Curves for growth (left) and rate of growth (right) for boys and girls. The growth spurt occurs earlier in girls, approximately between ages 10 and 14, and is more marked than in boys.

Source : TANNER. In : JEANNERET O., SAND E.A., DESCHAMPS J.P., MANCIAUX M. Les adolescents et leur santé. Paris, Flammarion Médecine Sciences ; Montréal, Presses de l'Université de Montréal. 1983. 484 p.

height between children of a same age within classes or groups of children. One child who was always smaller than his or her peers all of a sudden begins a growth spurt, and temporarily becomes taller than those who formerly looked down on him or her, but will soon be caught up with and again surpassed by them. In another, who has always been the tallest in his or her group, pubertal growth may begin at an early age, but it will also stop sooner, with precocious knitting together of the cartilages, and in the long run he or she will remain short. Indeed, the pubertal growth spurt is observed immediately before the end of height growth, which occurs toward age 16 in girls and age 18 in boys. Individuals who mature early may lose their temporary advantage because of prematurely arrested growth. This is evidenced by a comparison of the height development of boys and girls : since the latter begin their pubertal growth spurt earlier, they are taller and heavier, on the average, between ages 11 and 14, than boys of their age (figure 2).

Strength is increased, particularly in boys, by the considerable development of the musculature : often this only aggravates the consequences of youthful clumsiness.

Such a bodily upheaval is by no means neutral. The adolescent must adjust to a new body image, and accept a new self-image. Traditional cultural values apparently facilitate this adjustment. Facial painting, markings, physical exercises as well as use of jewelry and ornaments were symbols of the access to a new, different, sexually identified body, both acceptable and accepted. By contrast, urban development and the adoption of western-type values seem to make adjustment to and valuement of a new body image increasingly difficult. Many young people seem to be almost uncomfortable with their body, and perhaps even despise it. This may be the cause of some well-known difficulties, ranging from the lack of respect for one's self and one's body, shown by some types of sexual behaviour, to the use of toxic substances and risk-taking.

In European countries, adolescents are often obsessed with the fear of abnormal bodily and sexual development ; this has been called "dysmorphophobia". Without going to that extreme of considering it pathological, it does seem reasonable that health workers performing any medical examination recognize adolescents' difficulty in accepting their body, and provide the necessary reassurance as to the normal evolution of physical development. It would certainly also be preferable to retain the positive attitude of traditional cultures toward the child's body, and this starts at birth, with physical contact with the mother, massaging, play, stimulation, etc.

The epidemiological approach

The epidemiological approach to the health of adolescents and youth is now rather well documented in most developing countries. It is based on figures for mortality and morbidity, which are conventional health indicators, as well as on health-related behavioural data.

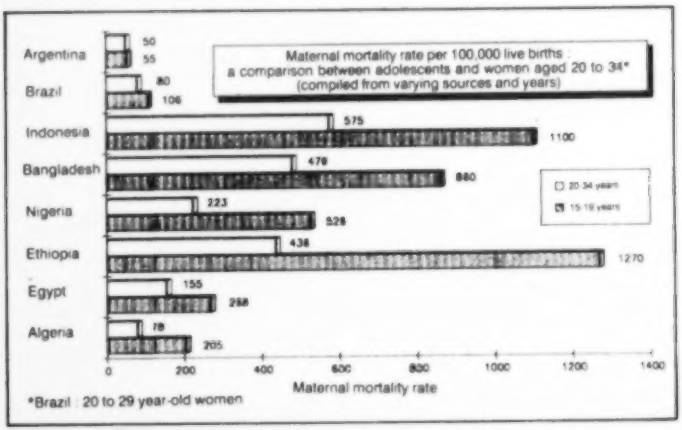
Mortality

Mortality is low in adolescents and youth, in comparison with other age groups. This fact is often viewed as an indication that there are few health problems at this time of life... The fact is simply that mortality is a poor health indicator at this age !

A study done by A. Soulimane in the Sidi-Bel-Abbès region of Algeria shows that the mortality rate of 10 to 19 year-olds is one fifteenth of the overall mortality rate, and nearly 100 times lower than the infantile mortality rate : adolescent deaths only represent 2 % of all deaths, whereas adolescents represent over 20 % of the population. A WHO study provides the following global figures.

Mortality rate (per 100.000)	5-14 years		15-19 years		20-24 years	
	M	F	M	F	M	F
Europe	38	25	97	40	133	46
Developing countries with medium-range income	116	113	151	97	271	139

There is no reason to be excessively reassured by these figures. Adolescent mortality in developing countries remains considerably higher than that observed in industrialized countries, the mortality rates do not decline at the same pace as in other age groups, and last, most deaths are due to avoidable causes : accidents, violence, suicides. In fact, the frequency of deaths from these causes tends to increase in urban areas. At the same time, although mortality due to respiratory and digestive diseases is low, it could still be considerably reduced. Last, mortality figures connected with pregnancy, childbirth, postpartum problems and voluntary abortion are particularly alarming.



In a March 1989 document on health for youth, WHO publishes a table comparing maternal mortality rates in different countries for 15-19 year-olds and 20-34 year-old women. The risk of death uring pregnancy and childbirth is 20 to 200 % greater for 15 to 19 year-olds than for older women.

Morbidity

Few studies are available on disease frequency, since notification is rarely adequate, and adolescents lack sufficient access to health facilities.

A. Soulimane has done an original study in Algeria, by collecting information on reasons for hospitalization, reasons for consultations in private practice and in health centres, the findings of school health services and last, the health status of a cohort of adolescents specially examined for investigation purposes. The findings are not generalizable to other countries, of course, but they are quite representative of the usual situation regarding adolescents.

In Sidi-Bel-Abbès, 2 to 3 % of adolescents are hospitalized each year : the majority are over 15. Most are treated in gynecology-obstetrics, followed by surgery. Hospitalizations in general medicine are in third position. The main causes of hospitalization are pregnancy and childbirth (48 % of hospitalizations for female patients), followed by "ill-defined syndromes and ailments" (30 % of hospitalizations), injuries (8 %), respiratory diseases (7 %) and digestive problems (5 %). In private practice, upper and lower respiratroy infections are the main reasons for consultations, followed by digestive ailments. The same is true in health centres.

Routine school health check-ups show more anomalies during adolescence than during childhood : impaired eyesight and dental caries are particularly frequent.

Last, findings for a representative sample of adolescents examined in Sidi-Bel-Abbès are summarized in the following table.

FREQUENCY OF DISORDERS OBSERVED IN 10 TO 19 YEAR-OLD ADOLESCENTS IN SIDI-BEL-ABBES

Type of disorder	Boys	Girls
Poor general health	16 %	12 %
Overweight	4 %	11 %
Dental Caries	51 %	51 %
Impaired eyesight	11 %	10 %
Disability	3 %	3 %

These findings do not indicate the existence of any specific health problems in young people. They do draw attention to dental health and sensory problems, which are sufficiently frequent to require specific preventive measures.

In conclusion, conventional indicators of morbidity seem to be disappointing. They do not coincide with pragmatic experience of the health problems of adolescents. The fact that traditional health indicators - mortality and morbidity - are unable to provide an adequate picture of the health status of adolescents and youth should be recognized. Another type of observation is required, placing greater emphasis on health-related behaviour as well as on "perceived health" ; that is, on how young people themselves feel about their health.

Health-related behaviour

Adolescents and youth have specific behaviour with respect to diet, sleep and life rhythms, sex, drinking, smoking, drug use and risk-taking... all of which affect their health, of course, to the point that their behaviour and its consequences are often viewed as youth's true health "problems".

Behaviour differs of course from one group to another, and from one country or ethnic group to another ; it is not the same in urban and in rural areas, at age 12 and at age 20, in high school students and in workers or unemployed youth. Any view of it as a uniform whole must be avoided : on the contrary, the diversity is such that each adolescent should be considered as an individual, over and beyond all resemblances, and the temptation to wield easy « clichés » about "youth" must be combatted.

Care must also be taken not to consider the "problems" connected with these types of behaviour as so many "illnesses", requiring prevention or treatment as separate entities. Much of this problem behaviour actually expresses young people's general malaise, their "mal-être" because they are disoriented and they lack an identity, social status, as well as the very beginnings of a life project. Instead of centering efforts around "drugs", "accidents" or "early, undesired pregnancies", they should also be directed toward the overall context - including the social and cultural one - of young people's problems.

It is not surprising that these problems are most pressing in urban settings. Only a few of these are analysed here. A separate chapter is devoted to the relations between sex and health.

Diet

Diet is particularly important during the rapid growth spurt that characterizes the onset of adolescence. Eating habits are usually disturbed in adolescents living in cities : in a study of a representative sample of Tunisian 14 to 17 year-old adolescents attending school, N. Gueddana et al. find that one out of three (more often girls than boys) eats "irregularly", usually for lack of time, but also to lose weight in some cases. Adolescents are extremely sensitive about their figure and their appearance, and some are particularly concerned about the risk of obesity.

In most countries, the increased intake of sweets, resulting mostly from the consumption of soft drinks, constitutes a true health problem for young people. This explains the frequency of dental

caries mentioned above, but may also result in a strong rise in the frequency of obesity and cardiovascular disease in the medium term.

The influence of health and nutritional status during early childhood on the health of youth and of menstruating girls in particular, and more specifically the aftermaths of malnutrition and infections, are now well known.

Any attempt to evaluate adolescent health should take these factors into account, so that specific "catch-up" programmes may be implemented when needed. Longitudinal investigations can provide the means for comparing the impact of programmes for dietary supplementation at puberty with those dealing with the same problems during pregnancy.

Smoking

Young people start to smoke at an increasingly early age, and developing countries all witness an alarming rise in the number of smokers, especially among girls. In Senegal, 70 % of 10 to 20 year-olds smoke, in Peru and Chile 45 %, and in Tunisia 30 %. Tobacco-linked disorders will soon take on terrible, epidemic proportions all around the world, with cancers, cardiovascular diseases, chronic bronchitis, difficult pregnancies, foetal repercussions and premature deaths. According to WHO, smoking reduces life expectancy in a proportion correlated with precociousness of beginning : by 8 years if smoking was started at age 15, by 4 years if it was started at age 25. It is a fact that 90 % of smokers begin before age 19. Smoking also has harmful short-term effects. In Sidi-Bel-Abbès, A. Soulimane found respiratory disorders to be 5 times as frequent in adolescents who smoke as in non-smokers (19 % as against 4 %).

Drinking

Like smoking, drinking is also on the rise among adolescents, and it begins at an increasingly early age. Boys still drink more than girls. In Nigeria, Zimbabwe, Chile and Uruguay, over 10 % of boys and young men are considered heavy drinkers. Abuse of alcohol mostly affects urban youth, in or out of school ; often it takes on an acute form, with frequent bouts of drunkenness. Like smoking, drinking is often associated with an image of maturity, sociability, an adult-like appearance. Alcohol is actually used like a readily available drug, since it may be produced at home or is easily purchased.

Drugs

Drug abuse is rapidly spreading among adolescents living in the big cities of the third world. High school and college students as well as the unemployed are most affected. Multiple drug abuse is increasingly frequent, with a combination of drinking, use of cannabis and/or of misused pharmaceuticals such as barbiturates and amphetamines. Cannabis is extensively consumed ; 45 % of youth in Brazil, 30 % in Zambia and India, 20 % in Nigeria, Kenya and Thailand, 15 % in Egypt have tried it : it is grown everywhere, and is given different names depending on the region or the mixture in which it is included.

The inhalation of glues, solvents or diluents (ether, acetone, kerosene or nail polish remover), which cause a feeling of inebriation, are increasingly used by younger children, sometimes as early as age 7 or 8.

According to a survey of 120 youths, conducted in Pikine, a suburb of Dakar, in 1980 :

- 102 had inhaled "geintz", a mixture of various solvents ;
- 79 smoked "yamba" (cannabis) on an everyday basis ;
- one third had taken sleeping pills or tranquillizers.

Drug use is a large-scale fact in the periphery of large cities, then. The consumption of "hard" drugs such as heroin and cocaine, on the other hand, is still quite low in comparison with other substances, although it is on the rise.

"The material and moral insecurity of these adolescents, and their anxiety with respect to their future in an uncertain environment, with its unemployment, urban sprawl, loss of traditional values and break-up of families, are the main causes of the extension of drug addiction, along with idleness, curiosity and the search for new sensations. It is probably also the consequence of the frustrations created by western-style development based on the dictatorship of consumerism.

These substances are purchased illegally, using a special coded language, or by the use of forged pharmaceutical prescriptions." (D. Poitou).

Risk-taking, accidents

The fact of taking a risk judged excessive by adults in regard of the advantages to be derived from a specific act is typical adolescent behaviour. The attraction to high risk situations, and even to obvious danger, a taste for the unknown and the previously unexplored, as well as for surpassing oneself, are profoundly human traits, and are more specially observable in adolescents and young adults. The need for discovery and self-accomplishment described by A. Maslow in his classification should be kept in mind here. Clearly, exploration of the "unknown" and risk-taking are inseparable. Adolescents are more likely than people of any other age to seek out risky activities, and to throw themselves into them, heedless of danger. Young people are still close to childhood discoveries, characterized by a lack of experience, a feeling of invulnerability and fearlessness, but they also have a clear, sometimes perspicacious view of the way many of their elders live. Risk-taking then represents a strong will to be independent, different and courageous, to change things, and a refusal to let oneself get bogged down.

Such behaviour explains the accident-caused pathology so frequent in adolescence, as well as many suicides and acts that may be either accidental or suicidal ; it also englobes some above-mentioned problems such as the refusal of contraception, undesired pregnancies, the consumption of noxious substances, etc.

Accidents are one of the main health problems of adolescents and youth : they alone cause 30 to 60 % of deaths in this age group, along with a great many permanent disabilities. They affect youth at the height of health, and result in the loss of a considerable number of "potential years of life".

Traffic accidents, drownings, burns, poisonings, wounds caused by firearms or blades are the main types of accidents. The frequency of traffic accidents tends to increase, owing to driving habits, the poor condition of many vehicles and drinking. In developing countries, young people go to work at an early age and often at jobs for which they are not apt : fatigue then increases the frequency of on-the-job accidents. The lack of labour regulations and appropriate prevention programmes further aggravates the situation.

Suicidal behaviour

Suicides and attempted suicides are on the rise among young people everywhere. Many accidents are most probably disguised or unrecognized suicides. In most countries, suicides are second only to accidents as a cause of death in adolescents and youth. Suicide attempts are more frequent in girls, but boys commit more "successful" suicides. According to a WHO document, disturbed family relationships are one of the most frequent causes of suicides. The pressure ensuing from migration to a city, isolation, intense competition at school and unemployment produces stress. Depressions, a frequent occurrence during adolescence, are a risk factor for suicide ; however, social factors, rather than mental disorders, are decisive in most suicides.

Perceived health

The usual health indicators are not very representative of the health status of adolescents and youth. It is more instructive to observe health behaviour, even when it does not result in immediately cataloguable health problems. Another way of approaching health in youth is to ask them their opinion, or to have them talk about their health, their problems, and what they need from health services. This type of approach is a necessary preamble to action aimed at promoting health in youth, since such action should be based primarily on their needs and demands, and give them an active part in maintaining their own health.

Unfortunately, few studies have investigated how young people perceive their health. Some interesting findings for North Africa have been uncovered by A. Soulimane in Algeria and N. Gueddana et al in Tunisia, however. Most adolescents (83 % in Sidi-Bel-Abbès and 72 % in Tunisia) consider themselves healthy... which is to say that a non-negligeable proportion (respectively 17 % and 28 %) have the impression that they are not in good health. Less than one out of two Algerian adolescents defines health as the absence of disease ; more than half define health as physical fitness, mental balance or even a happy family.

The frequency of the main health problems mentioned by Algerian adolescents is shown in the table below. Nervousness and fatigue

head the list, in differing proportions for boys and girls, followed by dental problems, underweight and (especially in girls) obesity. Digestive symptoms are quite frequent, particularly among girls, and may be an expression of psychosomatic disorders rather than of organic illness. Depression is rarely mentioned, perhaps because it is disguised in various ways, to which attention should be given. It should be noted that obesity is mentioned more often by adolescents than by physicians, possibly indicating these adolescents' malaise with respect to their body image.

DISORDERS CLAIMED BY 10 TO 19 YEARS-OLD ADOLESCENTS IN SIDI-BEL-ABBES, ALGERIA

Disorders	Sex : male	Sex femal
Fatigue	40 %	59 %
Nervousness	47 %	39 %
Dental problems	26 %	27 %
Thinness	21 %	29 %
Obesity	9 %	25 %
Gastric pain	5 %	11 %
Depression	3 %	1 %
Other	2 %	2 %

In the Tunisian study conducted by N. Gueddana et al. 37 % of adolescents had at least one complaint. Psychosomatic disorders were first on the list : the authors put "hurting all over", stomach pains and fainting under the heading of fatigue. Sleep disorders come next, followed by unspecified anxiety, enuresia 2 % of (adolescents). Nearly half of adolescent girls complained of dysmenorrhoea (painful menstruation). N. Gueddana combined several indicators of perceived health, in order to construct an original indicator of health status, showing that :

- 27 % of adolescents perceive their health as excellent ;
- 40 % of adolescents perceive their health as quite good ;
- 19 % of adolescents are in mediocre health ;
- 15 % of adolescents are in poor health.

She also found that girls' health status is definitely worse than that of boys, and that the proportion of adolescents in poor health is much greater in "older" adolescents, in economically underprivileged areas and when the family standard of living is low.

SEXUALITY AND HEALTH IN ADOLESCENCE

The first part of adolescence involves puberty. This is a series of major physical, biological and psychological transformations through which boys and girls gain the ability to have children.

The beginning of adolescence is therefore marked by a basic change in the individual's sexuality. Behaviour is considerably modified by the development of secondary sex characters and the exploration of emotional and genital relationships with partners of the other sex. Although adolescents are capable of sexual intercourse and reproduction, they are not necessarily in control of the many aspects of their sex life. This results in frequent difficulties, which tarnish this period of intense discovery of oneself and others, with its awakening to love and to fertility.

Sexual behaviour

In almost all countries, young people tend to have sexual intercourse at an increasingly early age. This trend is partially linked with the gradual lowering of the age of puberty, but it is predominantly the result of social factors, including the extension of sexual freedom as a recognized cultural model, loosened social and familial control over young people and the search for immediate satisfaction. Even in those societies where premarital sexual intercourse is traditionally taboo, young people are increasingly sexually active at a very early age. On the other hand, marriages are still celebrated at an early age, especially for girls, in many cultures, although age at marriage now tends to rise.

According to WHO, few national studies have been conducted on the age of first premarital sexual intercourse in third world countries. This conduct seems to be more common in developed countries and in Africa than in Latin America, Asia or the Middle East.

In one Nigerian study (Ibadan), over 20 % of the girls questioned claimed to have had their first experience with intercourse before age 15 and 50 % before age 16. In Brazil, as well as in Mexico, about 13 % of girls aged 15 to 17 claim to have had premarital sex. In the United States, the average age seems to be 16 ; in Thailand and in South Korea, on the other hand, less than 6 % of unmarried young women have an active sex life before age 19.

A seriously documented study was done by M. Crabbe in 1983 among high school students in Bangui (Central African Republic). Only 27 % of girls in the third form, whose average age was 18, claimed they had never had intercourse. The average age at first intercourse was 16 years and 9 months, or about 3 years after puberty. In boys, the average age at first intercourse was 15 years and 9 months. 16 % of third form girls were already living with a fiancé or a husband. Most girls had been pressed to have sex at a very early age. Rapes are apparently quite frequent. Often girls had their first intercourse as a result of a recent or passing encounter.

Most girls said they had been disappointed by this first contact. More than boys, they stress the emotional aspect of their sexual desire. Often they had many partners.

All these findings from different countries confirm the recent evolution of youthful sexual behaviour, and the concomitant risks : undesired pregnancies, voluntary abortions, sexually transmitted diseases, etc.

Although the fertility rate of women under 20 is declining, as in the other age groups, the number of pregnant adolescents is increasing : thus, in some parts of Africa and Latin America, 30 to 40 % of adolescent girls who mother children are under 18. There is evidence of a 31 % figure in Asia and 38 % in the United States.

At the Quito (Ecuador) maternity hospital, 20 % of deliveries involve girls under age 18. Overall fertility increases during the first years of adolescence, between ages 14 and 17 in the Ivory Coast, in Senegal and Cameroon, but also in Syria and Kenya.

Studies clearly show that early motherhood is correlated with greater risks, particularly in girls whose childhood was marked by malnutrition and infections, and who consequently lacked appropriate conditions for their own adequate growth and development. In Nigeria, the chances of dying during pregnancy are 4 to 8 times higher in pregnant girls under 15 than in those aged 15 to 19.

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Pregnancy and adolescence in Africa

■ JOSEPH M'BEDE

It is difficult to obtain an overall picture of statistics on pregnancy and adolescence in Africa, since the research done in different countries is not properly publicized. However, given the great similarities in the history and basic behavioural patterns of mankind, and of the peoples of sub-Saharan Africa in particular, the findings obtained in a few countries provide a relatively reliable picture of the actual situation.

Prior to our discussion of the epidemiological, obstetrical and social aspects of the problem, it should be noted that the pubertal period is rarely mentioned in investigations. It is a known fact, however, that age at menarche is susceptible of inter-individual and inter-group variations, and is also affected by genetic factors and socioeconomic level. In Cameroon, for instance, although 84 % of girls first menstruate between the ages of 13 and 15, the age at menarche may range from 11 to 18. In this study, adolescence is considered to include women who gave birth before their twentieth birthday.

Epidemiological aspects

Traditionally, African women were married very young, and this is still very much the case. In extreme instances, girls were married before puberty and raised by their husband's family until they reached child-bearing age. It is customary for women to have their first child at an early age, then, and pregnancy during adolescence is considered a normal occurrence. In western Cameroon, in 1964, women aged 10 to 19 represented 39.7 % of all women of child-bearing age, and 31.8 % of all deliveries : the specific fertility

rate was 43 per 1,000 for the 10-14 year-old age group and 248 per 1,000 for the 15-19 year-old group. A similar figure - 239 per 1,000 - is found in Niger. More recently, in Cameroon, the delivery room records of Yaoundé's Main Maternity Hospital showed that 3,117, or 25.8 % of the 12,100 women who gave birth there in 1983 were under 20, and 1,271, or 10.5 %, were under 18 (see table below).

DELIVERIES AT THE MAIN MATERNITY HOSPITAL, YAOUNDE, 1983

Mother's age	Nomber	Percentage
13 years	6	
14 years	28	
15 years	141	10,5
16 years	386	
17 years	710	
18 years	912	
19 years	934	15,3
under 20 years	3 117	25,8
over 20 years	8 983	74,2
TOTAL	12 100	100,0

A study conducted in a maternity ward of a university hospital in Abidjan found that 757 of the 13,627 parturients - 5.5 % - were adolescents.

A comparison of Cameroonese statistics for 1964 and 1983 shows that the relative fertility rate of girls under 20 dropped from 31.8 to 25.8 % in two decades, and with a changeover from a rural area to an urban area. This drop is even greater for girls under 15, since the rates are 5.5 % and 0.3 %. This indicates the extent of the sociocultural upheavals introduced by urban development and a modern economy.

The frequency of pregnancy in adolescents is extremely high in Africa, in comparison with western countries, then. It tends to decline, however, as life styles change : today's increasingly educated city girls no longer become socioeconomically active at adolescence, as was the case in traditional rural settings.

Obstetrical aspects

In Africa, where adequate prenatal surveillance is not available to all, by far, adolescent pregnancies should be viewed as at risk.

There is a risk for the mother : according to the Ivory Coast experience, which is still debated, the younger the girl, the greater is the risk of complications. These complications include gravidic toxaemia, pelvic anomalies, difficulty in expulsion owing to a scarred perineum, particularly in the many regions in which ritual excision is still performed. As a result, surgical interventions (episiotomy, caesarian section and occasionally hysterectomy) are more frequent in this group than in older women.

There is a risk for the foetus : the high risk of delivery of low-birth-weight babies is generally acknowledged. In Yaoundé, for instance, where children in this category - 74.2 % of whom are prematures - taken as a whole and for a period of several years, represent 11.6 to 12.5 % of all neonates, the proportion reaches 17.3 % in children born to mothers under 20, and about 20 % for mothers under 18.

ADOLESCENT DELIVERIES AT THE MAIN MATERNITY HOSPITAL OF YAOUNDE IN 1983

Mother 's age (years)	Number of deliveries	Number of children weighing less than 2 500 grams	
13 years	6	3	(50 %)
14 years	28	5	(17.8 %)
15 years	141	28	(19.8 %)
16 years	386	71	(18.4 %)
17 years	710	147	(20.7 %)
18 years	912	148	(16.2 %)
19 years	934	136	(14.5 %)
TOTAL	3 117	538	(17.3 %)

Children born to adolescent mothers have an extremely high rate of perinatal mortality, owing to obstetrical difficulties and to the high prevalence of low birth weight caused by prematurity or retarded intrauterine growth. A figure of 139 per 1,000 is reported for the Ivory Coast. In a neonatal unit in Yaoundé, 62.6 % of the 1,477 children admitted annually had a low birth weight. The overall mortality rate is 173 per 1,000, whereas the rate for neonates weighing less than 2,500 grams is 237 per 1,000.

Socioeconomic aspects

In practically all traditional African socioeconomic and cultural contexts, children are viewed as a blessing from heaven, and nothing enhances women's value more than motherhood. A pregnant adolescent, be she married or unmarried, therefore receives special attention. She usually returns to her own home, regardless of whether or not she is married, and is cared for by her mother and aunts, who prepare her for childbirth and continue to take care of her and her child long after delivery. Formerly, in many regions, when the young mother returned to her husband a younger sister or girl cousin was sometimes sent along to help her take care of the new baby. Under such circumstances, adolescents do not encounter any special psychological or emotional problem when pregnancy and childbirth procede normally, and on the contrary they are a source of fulfillment for everyone.

The picture has now changed completely, in urban settings, and even in villages, with the schooling of girls, poverty and modern socioeconomic constraints. Pregnancy in an adolescent may well be truly dramatic for the entire family. In Yaoundé, most pregnant adolescents are high school - or even elementary school - stu-

dents, while a few are in college. They have no paid job, and one out of two is unmarried.

In a study conducted between April 1974 and December 1975 in the same city, Abessolo found that, for 99 cases of illegal abortion ending in hospitalization, 94 % were city residents, 81 % were unmarried and 50 % were under 20 years old. The main reason given for recourse to illegal abortion was that pregnancy is a handicap to schooling, followed by a precarious material situation and the fear of parental reactions.

It is a fact that pregnant students are almost always forced to leave school, either on their own initiative or following exclusion. When they resume their studies, they have fallen far behind fellow students of their age, and may even find some establishments and competitive examinations closed to them, because they have passed the age limit. This explains some of the solutions chosen : resorting to various stratagems to hide pregnancy as long as possible, until the next test, or the next school holidays, illegal abortion, etc. Since abortion laws have not been liberalized in African countries, and young people do not have much money, they do not consult qualified physicians or competent medical establishments for abortions. Girls attempt to perform abortion on themselves, or consult some barely qualified person ; the technique used is often relatively ineffective and almost always dangerous.

Each year there are reports of newborn babies found alive or dead, abandoned by anonymous mothers, in the large cities of Africa. 31

Parents always react negatively when they learn that their daughter is pregnant. Not only do they feel dishonoured, but in addition, they fear the additional material burden, along with termination of the schooling for which they had nourished high hopes, and often made great sacrifices. There are many instances of parents chasing their pregnant adolescent daughter from their home. When the old African wisdom and tolerance finally prevails, the financial problem is not necessarily solved. In most cases the child is left with the grandmother, or even the great-grandmother who has remained in her village and takes care of it as she can. It is not surprising, then, that the most distressing cases of early malnutrition are encountered in this group of children.

In view of developing Africa's tremendous needs in all of the most fundamental domains, the problem of adolescent pregnancies has only recently been recognized as primordial. With the extraordinary expansion of the cities it has become an increasingly acute one, however. Some examples of the measures taken in Burkina Faso, in the Congo Republic and in Cameroon show that it is now being taken into consideration : abolition of exclusion from schools, authorization to repeat a year if school attendance was interrupted to the point that performance cannot be assessed, readmittance to school following childbirth, special funding allocated to girls who

had been scholarship-holders, recognition by the father of children born outside of marriage, equal rights for the latter and for legitimate children. The need to space births has gradually led to the acceptance of birth control methods in African countries, and sex education has been introduced in some schools. There is a felt need everywhere for a better regulation of sex life and a control of fertility, for the good of both women and families.

Abortion

■ JEAN-PIERRE DESCHAMPS

Many girls resort to abortion, but since abortion is illegal in most developing countries there is no way of knowing how many they are. Statistics only include those women who are hospitalized for post-abortion complications.

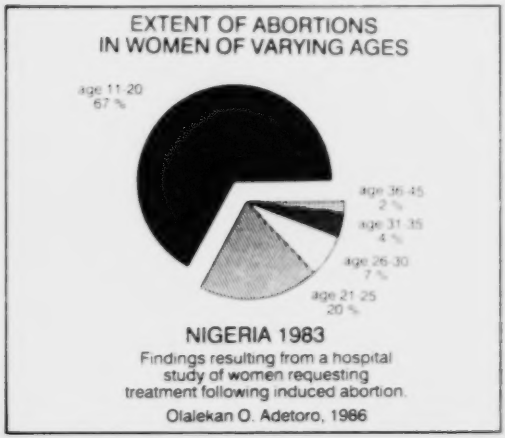
In Mali, Zaire and the Congo, for instance, 38 to 68 % of women who request treatment are under 20. In Peru, the figure is over 10 %. A study done in Nigeria shows that abortion in an adolescent is involved in 10 % of maternal deaths.

The diagram pictured below shows that 67 % of women treated following an abortion were 11 to 20 year-olds.

Contraception and planned parenthood

The problem of contraception for young people is raised by the fact of their early, often active sex life and the frequency of multiple partners.

Contraceptive techniques are rarely used, generally speaking. In the above-mentioned Bangui survey, the term was unknown to more than half of the high school girls questioned, most of whom were sexually active. Only 19 % of boys and 24 % of girls in the third form who had sexual intercourse used a contraceptive method, or had done so in the past. As a result, 42 % of third form girls had had at least one induced abortion, 49 % had had one or more pregnancies and 15 % were pregnant at the time. Many of these pregnancies were undesired. This situation is not an unusual one, as was shown in the previous chapter, and it has been corroborated by a number of investigations.



There are many obstacles to the use of contraception by young people. The case of adolescent girls (or boys) who truly want to have children is a separate question. Many girls are completely lost, with no prospect of finding any other social role or project, and are eager to become mothers as soon as possible. Like other early pregnancies, this type of pregnancy raises many problems, and requires help on the familial, educational and social levels.

For those young people who do not desire children, a great variety of factors is involved in the non-use of contraception. In many countries, use of contraceptive devices is only authorized, or tolerated, for married couples, or in the framework of planned parenthood, for couples who have already parented one or several children. Even when contraception is legally available for young people they often have little access to these services, and the cost is very high. The lack of proper information is undoubtedly a major factor : many adolescents are only informed by their peers or their partners, and have no idea of how to find a competent person to answer questions and give advice.

There are also many cultural obstacles. For example, M. Crabbe's survey in Bangui showed that boys viewed contraception as a practice that violates tradition, is a sign of cowardice, undermines society by depriving it of human beings to serve it and thwarts development. Misinformed boys and girls fear that contraception will cause sterility, medical complications and multiple pregnancies, or make sex less pleasurable.

Many boys also feel that contraception is not their problem, that they "don't run any risk", that that cannot happen, that it is up to the girl to take her precautions, etc. As a result, 7 % of boys in third form have children, and many do not know whether they have any ! Much remains to be done to achieve responsible sexual behaviour.

Regardless of whether or not they are married, young people in developing countries generally do not use contraception, or else use only ineffective methods. A number of culturally acceptable traditional or "natural" techniques result in failure, since they are based on erroneous information or a poor understanding of female physiology.

Recent studies in Colombia have shown that 46 % of sexually active girls aged 15 to 19 did not use any contraceptive method, although 21 % of them did not want to have a child at the time ; 17 % had become pregnant without wanting to and 8 % used an ineffective method.

In Liberia, most sexually active adolescent girls do not use any contraceptive method for lack of information or means, fear of contraception or wrong information about the possible outcome of sexual intercourse.

Contraception is more frequently practiced in developed countries. Oral contraception is mostly practiced in urban areas, but it is often improperly used, because of financial problems or difficulties in procuring pills. Physical barriers (diaphragm or condom) seem to be increasingly acceptable because they contribute to the prevention of sexually transmitted diseases, and more specifically of AIDS, but their use is limited by their high

cost. It should be noted that little is known about recourse to male contraception, but it seems to be infrequent in the third world.

Sexually transmitted diseases

The global recrudescence of sexually transmitted diseases (STD) over the last quarter of a century, approximately, is well documented. This increase mostly affects young people. According to the Bangui survey, one third of third form high school students and over half of high school seniors had a history of STD.

In the cities of most countries, where consultations specialized in the diagnosis and treatment of STD are available, more than half of consultants are under the age of 25.

STD are a major cause of sterility, especially in women, as well as of miscarriages and foetal contamination during pregnancy. The most frequent STD are gonorrhoea, Chlamydia trachomatis infections and genital herpes.

The extent and severity of the current AIDS epidemic has brought STD to the forefront. It is true that the transmission of AIDS, by which Africa is so seriously stricken, is furthered by a multiplicity of sexual partners, and that its prevention cannot be limited to the use of condoms, which are unfortunately quite costly, but also requires a change in patterns of sexual behaviour.

RESPONDING TO ADOLESCENT HEALTH NEEDS

Role of physicians

In a French survey, one adolescent is quoted as saying "I would like my relationship with a doctor to be a friendly one, where we could talk to each other : I see a doctor as being a counsellor and a confidant rather than a simple prescriber of pills".

Personal experience and a number of studies show this remark to be characteristic of what adolescents and youth view as an ideal relationship with health services.

The usual functioning of health services is quite inappropriate to this type of demand, and this inadequacy probably provides a partial explanation of their poor attendance by young people. It is not because they are "healthy" that adolescents consult infrequently. In fact, their health is not as good as is commonly believed, although the usual mortality and morbidity indicators are reassuring, as seen above. The feeling that health professionals are unable to listen to and relate to them leads many young people to choose not to consult, even if the help they need cannot necessarily be found elsewhere.

Adolescents expect health professionals to treat them as individuals, not as oversized children. They demand time, open-mindedness, a friendly ear and an ability to dialogue, along with specific information. As seen above, their health problems are essentially "psychosocial", and express a malaise, a feeling of general mal-être, difficulty in feeling at ease with oneself and the world, and anxiety about the future. All this cannot be treated by medications prescribed at the end of a hurried consultation, but requires dialogue, a true face-to-face relationship, a warm reception, discretion and respect of the confidential nature of the exchange.

Adolescents and youth are also more demanding than adults as to the quality of the services delivered. They are impatient with long waits, or what seem to be indiscrete questions. Since their rhythm and schedule often differs from that of adults, they find consultation hours too limited and rigid. Although they rarely formulate these complaints explicitly, they express their discontent by their non-use of services. They do not feel welcome... and do not come back.

These attitudes often produce hurt feelings among the personnel, who are unaccustomed to having users express demands as to the quality of their reception. In fact, the reactions of adolescents and youth serve to reveal some of the defects of health services : since they are more spontaneous and forthright than many adults, they are more apt to refuse inadequate services. It is probably they who are right, however, and health professionals should heed their message...

Role of adults

When an adolescent consults, what interests him or her is the possibility of establishing a satisfying relationship, rather than the professional status of the other person. In the case of a health professional, it does not matter much whether the person is a doctor or a nurse ; often a better relationship may be established with a nurse than with a doctor, actually, perhaps because nurses tend to be more open and less "directive" than doctors, and because nurses use less technical language than doctors. In fact, what adolescents need is contact with an adult, and not necessarily with a health professional.

Parents

This explains adolescents' great need for communication with their parents. Many surveys show that when adolescents are asked with whom they would like to discuss their health, they do not immediately think of doctors and nurses. They first mention their parents. This shows the need for the latter to be open to dialogue with their children when they become adolescents. Such dialogue is not always easy : parents often have the impression that their adolescents avoid contact, whereas the latter are often avidly seeking communication. Sometimes this dialogue may be easier with other members of the immediate family, such as uncles and aunts, or grandparents.

Grandparents

In many communities, young people customarily bring their problems to their uncle : every effort should be made to maintain this tradition. At the same time, as life expectancy tends to increase, adolescents have increased opportunities to see their grandparents, and frequently to be very close to them, often to the point of achieving great complicity with them. The values and opinions of adolescents often seem to be closer to those of their grandparents than to those of their parents. The role of grandparent is no doubt a more comfortable one than that of parent ; it is less supervisory and leaves more room for spontaneity, and at the same time, elderly people have more time to spare. Grandparents probably also have a more serene view of life than do parents, who are severely tried by the difficulties of urban development, migration, the search for employment, economic subsistence and cultural change.

Relations between adolescents and grandparents should be encouraged whenever possible. When the latter are absent - since families are often separated - any opportunity for youths to talk with elderly people is beneficial. Elderly people too will find this beneficial, since present modes of living often deprive them of any role in society.

Teachers

Other adults, outside of the family or the immediate entourage, may dialogue with adolescents in search of a sympathetic ear. Teachers may serve as a reference for all school-attending youth, provided the latter sense that they "feel good about themselves" and are open to dialogue. This is far from being the case of all teachers. Frequently, in any school, only a few teachers are

actively sought out by students, presumably to talk about their problems at school but in fact to talk about themselves, their life, their problems, just as they would talk to a doctor. Actually, one need not be a doctor to respond to this type of demand, and often a young person will be more inclined to consult a health professional if he or she has been encouraged to do so by a sympathetic adult.

Social workers, club leaders and religious leaders are also possible contacts for young people. The social or professional function is unimportant : what matters is that young people find someone with whom to talk, and also that they be left the choice of the right person.

Adults in general

It is self-evident that non-health professionals have a role to play in the health of adolescents and youth : all sectors touching on social life, in its educational, religious, economic, associative, women's rights, rural development and other aspects are concerned, as well as the health sector. There should be no need to recall that the health of adolescents and youth involves the possibility of fulfillment at school and the prospect of social, familial and vocational integration ; in other words, the ability to make projects, to plan for the future, and to play a role in society.

There is nothing worse for youth than the "no future" with which they are faced in the underprivileged parts of large cities, that vehicle dispair and cultural and social disintegration. Millions of young people around the world now experience a life with no visible future, where communication often knows no form other than physical and sexual violence, and escape means use of alcohol or drugs, while adult contacts are dealers and policemen. Little may be expected of health services under such conditions, and health for youth can only be meaningful within the context of true community development, in which youth can and should be partners, as will be shown below, and also when there is a real prospect of reducing social inequality.

School and health at school

Adolescents do not all receive an education. In rural areas and the poverty-stricken suburbs of the large cities, many are unable to attend school. And yet, the essential role played by mothers in infant growth, nutrition and development has long been a known fact, proved by many studies. Their general educational level, knowledge of health, hygiene and diet and their ability to adjust have a tremendous influence on their child's future.

Despite this, there are still countries in which the number of girls attending school is lower than the number of boys, and where many girls drop out or miss school often, and above all, where school programmes sorrily neglect health, both as a subject of knowledge, in its application to everyday family life and as personal experience, in school. School, it would seem, should dispense education for life, after all.

School may constitute a particularly good place to promote health, for those who attend it, by the very nature of the education it provides, and especially by including health education and sex education in the overall curriculum, by the ordered community life it offers as an experience and an example, by the fact that it groups people, making it easier to provide follow-up for an entire age group, and last, by the examples it may - or should - furnish in the fields of nutrition, safety and rhythms of life.

No doubt this extremely idealistic vision of the role of school is in contradiction with the prevailing state of affairs. School does not always offer fulfillment ; often it offers failure. Community life is frequently replaced by competition and the ignoring of others. Health education is often forgotten, as is sex education, the very principles of which are brutally contradicted by the behaviour of certain men-teachers toward their girl-students. School schedules are often in opposition with physiological needs, etc. This means that many opportunities to make school a health-promoting institution are lost, for lack of sufficient teacher training in adolescent health and development, because educational systems are maladjusted to the present-day realities of social evolution, and also for lack of efficient school health services.

School health services are frequently the health system's poor relatives. When they exist, their sphere of action is often limited to doing routine screening and first aid. These tasks should not be abandoned, but they should be integrated in a broader approach, within which their degree of priority can be determined in comparison with others.

For above all, school health teams should be "health contact people" within the school, and should help it to become that health-promoting place discussed above. This may be done in any number of ways : by responding to students, teachers and parents, and being available for them, by working to make health education an integral part of school activities and curriculum, by checking the quality of any food served, the sanitation of school facilities and the respect of biological rhythms, by helping to detect problem students, and contributing to the integration of disabled children and adolescents... in addition to perfoming traditional medical tasks, and acting as a meeting ground between the school and the general health services.

This is a vast programme, or rather, a series of objectives to be set, and which assume that school health services are recognized by those in charge of health policies as a high-priority element within health systems.

Adolescents and primary health care

A preparatory document for the 1989 World Health Assembly's technical discussions on "health for youth" proclaims that the principles that inspire primary health care - including responsibility for one's own health, participation, intersectorial action and appropriate technology - are particularly appropriate for the promotion of health among youth.

It must be admitted that there is little room for youth in what may be considered primary health care today. Mother and child health programmes are aimed at young children, but not at school age children or adolescents. Only pregnant adolescents or young mothers are occasionally covered by these services, and in some cases, young people who wish to use contraception or to learn about sex.

Pregnant adolescents and very young mothers are an extremely vulnerable group, as we have seen : even if the pregnancy is desired, as is often the case, its course and the prospect of motherhood raise medical, nutritional, emotional and social problems for the girl or young woman. Pregnancies in very young women tend to be more poorly monitored than others, or not monitored at all, even when prenatal health services are available. Nutritional supplementation with iron or folates is only rarely provided. And yet, properly conceived prenatal surveillance, coupled with educational action, has proved effective in many countries. In Nigeria, a study of 22,000 women showed a maternal mortality rate of 500 per 100,000 live births in mothers aged 14 or under who had received proper prenatal care, whereas the figure was 4,300 in those whose pregnancy had not been monitored.

It is a known fact that the younger the woman the more vulnerable she is and the less she attends health services. These women must be accompanied and given emotional and social support, particularly when they are in conflict or have broken with their family. Adolescents who are pregnant or are mothers should be a priority for mother and child health services. They should be considered not only as women faced with pregnancy or motherhood, but also as adolescents requiring help in facing the changes involved in adolescence along with pregnancy, in returning to school, eventually, and in avoiding an excessively short interval before their next pregnancy, when this is possible and desired. It is the young couple, or the young family as a whole, when it exists, that needs help and support, and it is in this context that the term "family health" is truly meaningful.

In Quito (Ecuador), 20 % of the approximately 13 to 14,000 women who come to the Isidro Ayoro hospital to deliver each year are under 18. These adolescents receive the same monitoring as adults. A study was conducted by an interprofessional team between 17th April and 17th July 1987 on 67 randomly selected adolescents attending consultations and under the age of 17 years 11 months.

The objective was to determine and analyse the biological and psychosocial situation of pregnant adolescents in order to test health monitoring, educational and psychosocial support programmes during pregnancy, childbirth and the postnatal period, before recommending their implementation at a national level.

This type of approach should naturally be accompanied by action to prevent pregnancy in adolescents.

Adolescents, both girls and boys, also need mother and child health services for the many aspects of education on sex and parenthood, and family planning. Sex education should not be left to health services only, of course. Parents, grandparents and teachers also have an important role to play (to do so, however, they must have access to advice and reassurance from health professionals, be they nurses, midwives or doctors). Doctor M. Crabbe, who has considerable experience in the Central African Republic, has enumerated the objectives of sex education as an integral part of everyday life and of general education :

— to show the transcendal nature of sex and love ;
— to induce respect for life ;
— to contribute to a sense of responsibility for oneself and for others ;
— to inculcate a sense of effort and self-control ;
— to contribute to knowledge of oneself ;
— to help formulate reference criteria for making judgements and choices in life.

The following text, by P. Erny, describes the principles involved in doing sex education work with groups of adolescents.

Some principles of group work in sex education

■ PIERRE ERNY

Often professionals with a recognized competence - doctors, psychologists, specialized educators, etc - are called upon to work with groups of adolescents, to provide information and help them to reflect on their sexual difficulties. The author's experience, both with groups of African youth and with French youth, has showed the utility of some simple principles on which it is important to base work in this specific domain.

First, one must make sure that the presence of these people is really appropriate and desired by the adolescents themselves, and not simply by their parents or teachers. It is preferable to delay an action, however necessary it may seem, rather than to impose it on a hostile or indifferent group. When animators are called in, it is a good idea for at least part of the initiative be taken by the young people themselves, with some sort of participation in the concrete steps. The action is only effective if it is awaited and prepared, rather than passively accepted.

Even when a group is highly motivated, the reason for an outside person's presence may not be clearly perceived by all of its members. Further, since the discussion deals with questions that "are not talked about" openly, perhaps, or that cause embarrassment because of some taboos, or simply because of lack of familiarity with an appropriate way of discussing them, it is preferable to begin with a short presentation of the types of subjects that may be dealt with. The aim of this talk is to raise problems (and not to solve them) ; it serves as a "green light", showing that sex may be discussed freely and seriously, and in

what terms. It attempts to establish a permissive atmosphere, while providing a language and some basic information. Its goal is reached if it is sufficiently explicit and simultaneously sufficiently general to serve as a call for free expression.

One of the main difficulties encountered by educators resides in the fact that groups of adolescents are not homogeneous with respect to information and sensitivity. Individuals of a same age may be at very different points of their pubertal evolution. Their sensitivity varies considerably with their environment, family, friends and temperament. One may be totally ignorant and the next very well informed, or think him or herself informed. Some only have access to fantasy, while others can speak from experience. There are also those who, for psychological reasons, tend to refuse any objective information on problems they attempt to deny : in some cases, fortunately infrequent, a clumsy intervention that forces a psychological block may be traumatic. Given the extent of these disparities, the educator's first basic attitude should be to take each individual as he or she is, in his or her present situation.

This is of course only possible if the young people are allowed to express themselves, and if attention is truly paid to their language. It is certainly important to note what they say, but also what they leave out, the way in which they express themselves and even more, the difficulties they experience in expressing things, their conscious reticences and unconscious resistances. This implies a certain type of educational philosophy, using small groups, a permissive attitude and a sufficiently attentive, constant presence. It means that the educator must feel quite free, personally, to answer any question raised, but must also be capable of saying nothing, and listening, and of sensing the hidden requests and silent calls for help from some young people, under the disguise of questions. Every adolescent has questions with regard to sex : it is already quite an achievement to enable them to become aware of their interrogations, and to formulate them clearly, using words that have been emptied of their emotional content and their burdensome imaginary connotations. A properly formulated problem is more than half solved.

Information in itself is of course an important part of meetings of this type. It is of several kinds :

— basic information required to open the debate and provide an adequate vocabulary through which the young people may express themselves : anatomy of the genitalia, physiology of sexual intercourse, the orgasm, fertility, gestation, childbirth, and of the biological cycles, sex-linked psychological differences ;

— complementary information requested by the young people when they feel sufficiently at ease : contraceptive techniques, premarital sex, etc ;

— information demanded unwittingly by their questions.

It should also be remembered that one question may always hide another one. When a speaker dealing with anatomy and physiology is questioned about quintuplets, siamese twins or extrauterine

pregnancies, there is no doubt that these are true questions, requiring answers as such, but they often are asked to fill a silence or to mask other questions that one does not dare to put because they are usually disapproved or viewed in too emotional a way. When the animator senses that the group is paralysed by obstacles of this type, he or she may suggest that people write down what they have to say, either anonymously, or after consulting one another.

Often adolescents will say, or more often write, surprising things, using a completely unexpected vocabulary and expressions, or approaching the problem in a way the adult had really never thought of. These peculiarities require close attention ; not only each culture, but also each milieu, each generation and each local group has its own language, its own way of thinking, its own obsessions, etc, which may be quite revealing and should be taken into account. Within a school, for instance, one encounters a combination of statements heard at home, information gained from lectures and books, as well as the ideas and ramblings of the adolescent group that gradually take shape through informal discussion, joking, boarding school experience, etc. The mixture may be difficult to separate out, but may also be of tremendous psycho-sociological and anthropological value.

At this point, regardless of whether one desires it or not, rejoices at it or regrets it, there is no way of avoiding a discussion of how life is conducted - that is, a specifically ethical reflexion. But this is, admittedly, the most delicate point, the one at which adolescents are waiting to get us, so to speak.

We have always contended that the role of the group leader is not to define norms and rules (and this stance has occasionally met with hostility from people who propose a ready-made ethical code). We have repeatedly stressed to adolescents that noone has the right or the ability to validly make decisions for them ; that in the last analysis it is up to them, and to them only, to make a happy life for themselves and to make conscious, responsible choices with respect to the major questions that will guide their conduct and orient their life.

To show that we have no intention to "preach to them" and to avoid any ambiguity, we make a point of excluding as radically as possible from our speech any reference to the categories of good and bad, forbidden and acceptable, or even normal and pathological. Not that these categories are meaningless for us, of course, nor do we wish to bury them in a complete relativism of some sort, an axiological indifference or intrinsic neutralism. But they are usually so laden with hasty, false value judgements totally lacking in respect for other people's choices, that it is necessary to cause a shock, in a sense, by deliberately opting for another perspective and another language.

What, then, do we have to say and to offer ?

Above all, we must provide food for thought, based on biological, medical, psychological, historical, social and cultural facts, in a

precise enough form to enable the adolescents to whom we address ourselves to forge their own personal opinion based on full knowledge of the facts, so as to be better prepared to shoulder their responsibilities. It is most important that they be adequately informed on the major problems with which they are faced, so that they may see them clearly, after which they may be helped to examine the different possible attitudes, weigh the pros and cons, the advantages and disadvantages and last, to discover the implications of each decision, and what is at stake.

In our opinion this is the most respectful attitude toward people who are both hesitant and demanding, who fiercely defend their right to make their own judgement, and who must use their own creativity to find their place in a pluralistic society in which everything is a matter of choice, and there is no longer any predetermined order. The objective is to enlighten their minds as objectively as possible, to confront them with their responsibilities, without either dramatizing or minimizing these, and to prepare them for the decisions they must necessarily make on their own. This in no way prevents other people from giving them more structured moral views, especially if the adolescents themselves are interested and request them. But this is another type of intervention, and it is not a good idea to mix approaches.

Four logically sequential steps may be defined for this type of group work :

— first, attention is paid to the terms and context in which the adolescents raise and deal with problems, listening to the silences, facial expressions and group reactions as well as to the words themselves. Explanations are requested for unclear expressions, without introducing any new elements, and the whole question is reformulated ;
— next, any gap or weakness in the formulation is pointed out, and the adolescents are helped to discover that other elements are involved, and must be taken into account if the problem is to be considered in all of its complexity ;
— for each question, a number of possible attitudes are shown, each having its own reasons, implications and consequences ;
— last, emphasis is placed on the need for a choice, and the criteria on which such a choice may be based are indicated.

In the course of discussion, especially once it has become lively, group leaders who have adopted an actively neutral attitude until then are frequently asked what their response is, how they would deal or have dealt in the past with a given problem in their own life. In our opinion there is no use in inducing questions of this type if they do not come up spontaneously, but on the other hand they are legitimate, and should not be avoided. It is by accepting to reply truthfully and sincerely, and to involve themselves personally and by acknowledging the fact that they embody one of a number of possible models for conduct, that group leaders fulfill their educational mission most radically. The ideal education would unquestionably require that leaders with differing orientations

succeed in establishing a harmonious, mutually respectful collaboration, while expressing their personal views if the group so desires.

Last, we believe that it is preferable for interventions on a group level be accompanied or followed by personal contacts with the group leaders for those who seek these.

Conclusion : because this type of approach is non-directive, it will always be rejected by all those people who, whatever their credo have ready-made truths to offer, inculcate or impose. Like every educational approach that aims less at transmitting knowledge than at maturing attitudes, it proceedes slowly, and takes time, requiring that its pace be adjusted to the needs of each group, with repetitions, in some cases. What the leader has to say is definitely important, but the beneficial or harmful character of any intervention depends essentially on what kind of person he or she is, deep down. If he or she is lucid and self-accepting, capable of dealing with these problems in an uninhibited but not a crude fashion, exempt of anxiety, excitement and tension and devoid of proselytism or exhibitionism of any sort, if his or her manner is calm, natural and uncomplexed as well as free and respectful, then that person may help youthful minds to mature and learn self-regulation.

Mother and child health services are not the only ones to deal with adolescents and youth in the framework of primary health care. In fact, every basic service is sollicited by adolescents. This means that all health professionals should receive training and preparation in work with adolescents, in accordance with the ideas discussed above.

The most important part of primary health care involves inducing young people to participate effectively in the promotion of their own health and ultimately in the health of the entire community.

Participation of youth in the promotion of health

"This participation, says a document published by WHO in 1986, cannot be obtained without serious support from health agencies and other sectors, and without a positive attitude among health care providers. Appropriate information, education, training and support are required at the outset, to ensure effective participation."

The working group that established these principles has suggested a "classification of health problems according to the degree of individual and community self-responsibility that may be achieved by providing the community with as much of the necessary knowledge, skills, techniques and authority as possible".

The working group then classed the different care levels that may be provided in the framework of a health programme as follows :

- self-care ;
- care provided by youth ;

— care provided by youth, but in collaboration with health establishments ;
— health care provided by institutions, with the participation of youth.

At the least formal levels, where emphasis is placed on prevention, information and social support services are required. The more formal levels tend to be involved in curative work for which more equipment and technical skills are necessary, and which are therefore more expensive. The health sector should be capable of providing reliable technical information, monitoring the distribution of material and furnishing technical skills, facilities and equipment, depending on the care level.

Here are some examples of health problems that may be dealt with at each level :

- **Self-care :** smoking, poor dietary habits.
- **Care provided by youth groups :** drinking, risk-taking resulting in accidents or undesired pregnancy, weight disorders, adjustment of reactions to stress.
- **Care provided by youth groups in collaboration with health establishments :** workplace sanitation, pregnancy, sexually transmitted diseases, suicidal behaviour, incapacitation following an accident.
- **Health care provided by institutions, with the participation of youth :** speech and language disorders, growth and developmental disorders, abortion, acute and chronic pelvic inflammation, deviant sexual behaviour, pathological depression, chronic, disabling diseases.

Perhaps the best way to promote normal development in youth is through community-based youth centres making use of local resources and adopting an overall approach to the needs of young people instead of dealing with each need separately. This type of approach is particularly effective with youth and may go beyond the immediate problems, to their causes, and facilitate personal development.

It is important that young people participate in the planning and delivery of services. Young users of multiservice centres generally view themselves as members of a club that makes those services available, rather than as patients attending conventional health establishments.

Ease of access, a flexible structure, a friendly, relaxed atmosphere and the possibility of participating in a variety of activities contribute to this impression. A high level of commitment, flexibility and the ability to take risks are some of the qualities required of people working in such centres.

It is most important that health agents be made aware of the specific needs of youth. The success of this type of approach depends on their capacity to listen to young people and to respect their feelings, to allow them to partake in decision-making, to share information with them and teach them skills ; these agents must also be trained in the necessary techniques.

Some examples of participation

The following examples are also taken from the 1986 WHO document.

In Nigeria, in the framework of the National Youth Service Corps launched in 1973, all holders of diplomas from universities or higher educational facilities are obliged to work for the government during the year following their graduation. During that year, they work in their own specialty in either a rural or an urban community, and participate in community development programmes such as the inventorying of needs and resources within the community, or at construction projects. This programme has provided doctors for rural areas, in particular.

In Jamaica, the project of a centre for adolescent mothers is an example of an innovative solution through which young people may participate in the satisfaction of their health needs within the broader context of their needs with respect to education and employment. This project was launched by the Jamaican Women's Bureau so that pregnant schoolgirls who are forced by social reprobation to leave school may continue their studies. The programme stresses practical training for family life and encourages group discussion and participation. The putative fathers also participate in an important programme aimed at increasing their awareness of their role within the family and of the incumbent responsibilities. Between 1978 and 1981, over 400 young women participated in this project, and more than two thirds of them subsequently returned to school. The project was especially useful in giving them greater self-confidence and developing their ability to plan for the future, with the feeling that they have some control over that future. The impact of the Centre is not limited to Jamaica ; it also serves as an example for other countries in the Carribean area that are concerned with the promotion of adolescent health.

In England, the Planned parenthood association has set up an experimental project called "Grapevine" in two London suburbs in which the percentage of illegitimate births is twice the national average. This project uses a communication network developed by other services, as well as publicizing by word of mouth, to make itself known to young people who tend to ignore conventional services. The participation of 16 to 30 year-olds in running health education and prevention programmes for youth of the same age ensures the appropriateness of the information provided. The project uses volunteers, each of whom is specialized in a definite type of work such as action in coffeehouses, youth clubs or on the streets, or "hot-line" telephone counselling services at the Centre itself. These volunteers also participate in planning and decision-

making, recruiting more volunteers and conducting some working groups. The professional staff works in collaboration with public and volunteer agencies. Ongoing evaluation is conducted in order to judge the need for modifications of any sort, as well as the project's utility as a model for action in other fields.

"The Door - A Centre of Alternatives" was set up in New York City (USA) in 1972 on the recommendation of a group of young professionals who believed that the vital needs of urban youth could not be addressed without a new approach to services aimed at young people. "The Door" was to serve as a model that would demonstrate the effectiveness of complete, integrated services and of networks and associations between existing systems. Over 400 young people from the entire New York metropolitan area attend the Centre daily. They find a broad range of activities and services, easily accessible and all under the same roof, within an architectural setting that creates a friendly atmosphere conducive to a certain degree of intimacy. For thousands of disadvantaged adolescents, the Centre represents a viable alternative to a self-destructive way of life, and provides an acceptable source of help for young people who are unable to turn to conventional agencies and establishments, or have no opportunity to do so.

"The Hub" is a centre for adolescents in the Bronx, New York, where some young people have been recruited and trained in interviewing, information-collecting and the assessment of the needs of local youth. Drug abuse and pregnancy were found to be the main problems facing youth in this disrupted community. The young people then helped set up a new youth health programme which has now been turned into a peer-group education programme.

In Mexico City and the neighbouring region, Centres for the orientation of adolescents (CORA), which began to function in 1978, have adopted a multiservice approach to respond to adolescent needs. Pilot prevention programmes provide advancement, educational, medical, psychological and cultural services and recreational activities for normal 11 to 19 year-old adolescents. Planned parenthood, information and consultation on sexual matters and gynecological services are also available. In the framework of their planned parenthood work, the centres provide other services in a joyful, healthy "social club" atmosphere that contrasts with the atmosphere prevailing in conventional dispensaries. These centres also have a mobile unit, and allow young people to participate actively in community development.

In Canada, the Regina Multiservice youth centre provides another example of a participative formula. Since 1982, a team composed of community members, specialists in adolescent problems and youth leaders have been working to set up a multiservice youth centre in Regina, using community resources and innovative approaches. Young people participate in the conception of the services, and to some extent, in providing them. The staff includes specially trained youth. Rather than concerning itself exclusively with problems, the Centre has set as its objective the encourage-

ment of normal growth and development. With the help of monitors and other workers in the Centre, and within the framework of programmes for the training of group leaders, young people who wish to work as group leaders for young people of their own age may express their opinions, conceive and implement projects and be of help to youth and to the community in general.

The project for at-risk youth set up in Los Angeles (USA) combines the resources of the Los Angeles children's hospital with those of the Los Angeles free clinic in its work with at-risk adolescents. The target population, composed of runaways and youth on the streets, has all sorts of health and social problems. The staff in charge of this project includes adolescents who have received special training so as to be able to counsel people of their own age.

A model for organizing health services for and with young people

The question of the nature of the health services to be provided for young people is in the minds of health officials everywhere. The most basic and most frequently raised issue is whether there should be special services for (and with) youth, or on the contrary, whether youth should use the health services available to the population as a whole. In the latter case, young people must receive specific attention from a motivated, trained staff capable of responding to their needs and demands with respect to health and ready to accept their collaboration in running the services.

The previous chapter has already partially answered this question by providing examples, mostly taken from industrialized countries, of services specifically designed for youth. These services are interesting as models for the participation of youth in running them. Yet the fact that they are few in number is clear evidence that they are far from representing a full solution to the problem of use of health services by youth.

It is preferable, then, that a more complete model be established ; one which, although providing a specific response to the needs of youth, would be compatible with the usual functioning of care services. This is the general idea of the module for the management of adolescent health problems in developing countries, designed by Professor O. Jeanneret at the request of WHO.

Prof. Jeanneret first recalls the recommendations adopted for services and programmes aimed at youth. These should :

— be kept small ;
— be an appropriate response to the needs and priorities of each country ;
— be founded on basic factual information resulting from field investigations ;
— call upon community participation ;
— be given careful follow-up and evaluation.

Next he draws a plan, or module, which classically takes into account a double division within care services :

— between curative care and preventive care ;
— between general care services and specialized services.

These four fields define four sectors in which a variety of services may be developed :

— the general curative sector ;
— the specialized curative sector ;
— the general preventive sector ;
— the specialized preventive sector.

In the modular diagram, the seemingly most important service is located in the centre, and involves information, guidance and counselling : the importance of these functions in our response to adolescents' health needs has been discussed above. Branching out from this "vital centre", the first services encountered deal with primary health care : education for health, sex education, pre and post-natal care, ambulatory consultations. Once again, we find the necessary preeminence of primary health care.

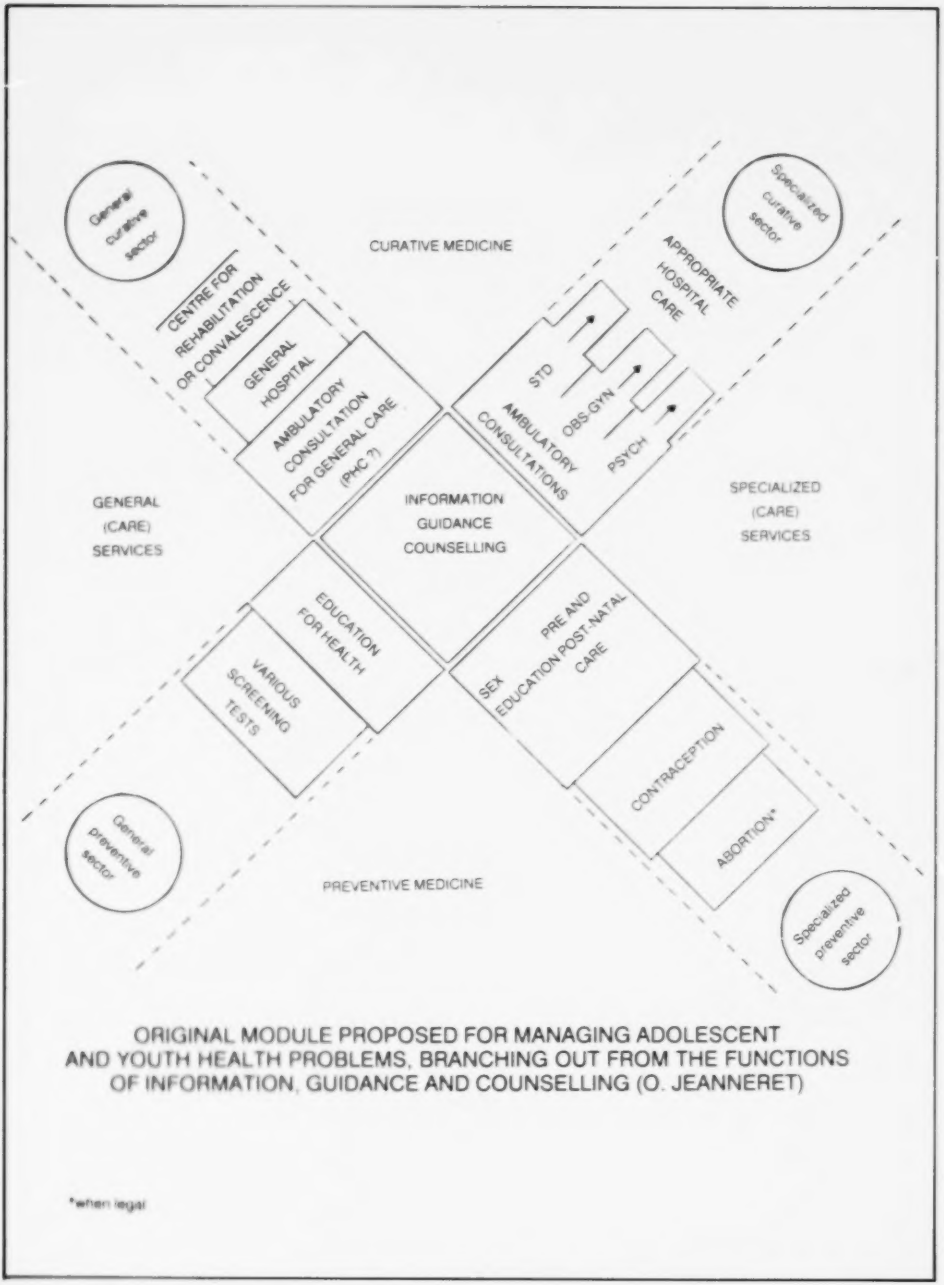
O. Jeanneret also points out that the proposed model is in no way specific to adolescents. "Indeed, for many developing countries, it is out of the question to suggest the implementation of new - and therefore costly - structures such as those set up in recent decades in the USA, followed by other western countries, before every effort has been made to exploit all of the possibilities of the existing structures, regardless of whether they are more specifically aimed at school-age children (school health services) or at adults (clinics and polyclinics). Such recourse naturally requires some adjustments, which these units are not necessarily disposed, prepared and/or equipped to accomplish, even when they are specialized in fertility and/or reproduction problems." This leads to the well-known difficulties usually described in terms of non-availability, non-accessibility and non-acceptability of services.

Thus, the centre of this set-up should be :

— specific to this age group ;
— open, accessible, acceptable and attractive ;
— staffed with well-prepared workers, sensitive to the problems as well as capable of motivating workers in the different services to deal with adolescent "clients", and of encouraging the latter to attend these ;
— able, in this way, to create channels for handling adolescent problems, often through personal relations.

There is no reason not to allow young people to manage certain centres themselves, in order to facilitate first contacts and the establishment of good personal relations. What counts most is that this staff be properly trained in these delicate tasks, and not content itself with knowing how to behave in a way that is sympathetic to others, but achieve a "know-how" that makes it credible to those with whom it is in contact, and more specially to workers in the back-up health services.

This model for the organization of care for adolescents is extremely flexible, and may be adjusted to a variety of situations (urban, rural...). It satisfies the basic requirements discussed above : priority is given to counselling and dialogue, and primary health care services are used to a maximum. "It is quite conceivable for the team in charge of the central facility to be mobile : it would then tend to branch out from its usual work context, since it would be called upon - as a group or individually - for training or refresher seminars for teachers, informative meetings with groups of parents, sessions to sensitize decision-makers, etc (...). Within an even broader context, we may imagine this integration extending even to programmes whose scope extends beyond the boundaries of health, in the limited sense of the term, to the existential difficulties and concerns of youth, such as unemployment and its consequences".



ORIGINAL MODULE PROPOSED FOR MANAGING ADOLESCENT AND YOUTH HEALTH PROBLEMS, BRANCHING OUT FROM THE FUNCTIONS OF INFORMATION, GUIDANCE AND COUNSELLING (O. JEANNERET)

*when legal

APPENDIX

CHARTER OF HEALTH FOR YOUTH

In preparation for the 1989 World Health Assembly, a number of young people and health professionals attended a colloquium held in Nancy (France). Together, they drew up the following "charter of health for youth".

Preamble

A group of young people aged 16-25 and of professionals (health professionals, teachers, social workers...) met with the intention to reflect collectively on health in reference to the Ottawa Charter for the promotion of health ; they assert the right of youth to health and define the incumbent obligations for themselves.

The following proposals were formulated as a basis for the elaboration of policies and programmes aimed at furthering the health of youth in their different settings, in collaboration with parents and other people with whom they are in close contact :

Point 1. First, youth and professionals must respect each other and recognize each other's values and differences, and the unique nature of each individual.

Point 2. Youth and professionals determined to engage in and pursue a dialogue should make an effort to listen to each other and to express themselves in a comprehensible manner.

Point 3. Professionals must attempt to understand and accept certain types of behaviour or expressions used by young people as a means of asserting themselves, without automatically labelling them deviant or pathological.

Point 4. Youth and professionals must work together to define the health problems of youth and to seek and implement solutions.

Point 5. The solutions suggested for the improvement of the health of young people must be appropriate to the multiplicity of individual contexts and to the practices of professionals, and respectful of their technical and ethical exigencies.

Point 6. It is important that young people be given the opportunity to choose the person they consult, and that professionals be given the information and training required in order to help, guide and dialogue with them.

Point 7. The preeminent role of the family in the promotion of health should be recognized, and joint informative and sensitizing action should be organized for youth and parents (or educators) so that they may think and act together.

Point 8. There is an urgent need for decision-makers and professionals to work with young people in defining ways to improve their health by combatting the financial, cultural and psychological obstacles that limit access to care and to health.

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HEALTH FOR ADOLESCENTS AND YOUTH

1989 - N° 180

In both industrialized and developing countries, adolescents and youth form a large part of the population, but for officials their health profile is a new, sometimes disturbing issue, too often summed up as "PROBLEMS".

What is at stake here is a better understanding and definition of their health needs, and particularly of the psychosocial aspects of these, through a methodology based on the active participation of adolescents and youth. This approach sollicits their commitment to the search for and implementation of more appropriate, occasionally original solutions, and may gradually reveal the positive values of this age group by bringing out its qualities and its potential.